Inquiry and Insight: Exploring Indigenous Perspectives on IPC

Presented by the National Indian Health Board and the National Council of Urban Indian Health

Project Firstline is a national collaborative led by the U.S. Centers for Disease Control and Prevention (CDC) to provide infection control training and education to frontline healthcare workers and public health personnel. National Association of County and City Health Officials (NACCHO) is proud to partner with Project Firstline to host the NACCHO Healthcare Infection Prevention and Control Summit (Summit), as supported through CDC Grant #6NU38OT000306-03-05. CDC is an agency within the Department of Health and Human Services (HHS). This presentation is being hosted as part of the Summit; the contents of this presentation and Summit do not necessarily represent the policies of CDC or HHS and should not be considered an endorsement by the Federal Government.
Presenters

Tyrone Peterson, MPH (he/him)
Navajo & Yaqui
Infectious Disease Associate
NIHB

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Mashpee Wampanoag
Public Health Associate
NCUIH

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Fort Peck Assiniboine/Sioux
Public Health Program Manager
NCUIH
Chicago resides on the traditional Territories of the Three Fire Peoples - the Ojibwe, Odawa, and Bodewadmi, purchased after two and a half years of open warfare, decades of violent encroachment, and the defeat of a pan-Indian movement to keep settlers out of the Great Lakes region at the Treaty of Chicago in 1821, receiving their final payment before moving westward in 1835. The area was also a site of trade, gathering, and healing for more than a dozen other Native tribes.

The state of Illinois is currently home to more than 75,000 tribal members, and the Chicagoland area is currently home to one of the largest and most diverse urban Native communities in the U.S. Illinois is also the territory of Ho-Chunk, Miami, Inoka, Menominee, Sac, Fox, and their descendants.

By making a land acknowledgment, we recognize that Indigenous peoples are the traditional stewards of the land that we now occupy, living here long before Chicago was a city and still thriving here today. As we work, study, live, and play on these territories we must ask what we can do to right the historic wrongs of colonization and state violence, and support Indigenous communities' struggles for self-determination and sovereignty.
Learning Objectives

1. Provide a basic understanding of Indigenous, American Indian/Alaska Native (AI/AN), and Native American identities.
2. Give an overview of the Indian Health System.
3. Examine the achievements of NIHB and NCUIH through the Project Firstline Initiative.
4. Discuss how external stakeholders can contribute to expanding and strengthening the capacity, collaboration, and coordination surrounding infection prevention and control in I/T/U facilities.
Defining Indigenous and Native American

**Indigenous**: originating or occurring naturally in a particular place; native

**American Indian/Alaska Native**: people having origins in any of the original peoples of North, South America, and Central America, who maintain tribal affiliation or community attachment

(Census & Office of Minority Health)

**American Indian/Alaska Native**: someone who has blood degree from and is recognized as such by a federally recognized tribe or village (as an enrolled tribal member) and/or the United States

(Bureau of Indian Affairs)

**Other terms**: Native American, Native

**Citizen vs. Member**
Historical Contexts

- Colonial Period (1492-1829)
- Removal, Reservation & Treaty Period (1838-1887)
- Trail of Tears
- Dawes Act (Allotment) Act
- Allotment & Assimilation Period (1887-1934)
- Boarding Schools
- Allotment & Land Sales End
- Indian Reorganization Period (1934-1945)
- Federal Programs to Support Tribal Governments
- >100 Tribes Terminated
- IHS established in 1955
- Relocation to Cities in 1956

Estimated 90 million acres (2/3 of the size of the US) lost
Congress declared the policy of the Nation "in fulfillment of its special responsibilities and legal obligations to the American Indian people to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy."
Indian Health System

Indian Health Service
- Federally Run Facilities

Tribal
- Contract or Compact Facilities

Urban Indian Organizations
- IHS Funded Native Health Nonprofits
Place a pin where your organization is located!
Total Number of Tribes Served at Urban Indian Organizations

500+ Tribes Served

- 505 Tribes (87.5%)
- 72 Tribes (12.5%)

Source: Indian Health Service, Calendar Year 2021 Data
How many federally recognized tribes are in the United States?

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>562</td>
<td>0%</td>
</tr>
<tr>
<td>574</td>
<td>0%</td>
</tr>
<tr>
<td>600</td>
<td>0%</td>
</tr>
</tbody>
</table>
Census Statistics

• As of 2020, 9.7 million people identified as American Indian and Alaska Native (AI/AN) alone or in combination with another ethnicity, 2.9% of total U.S. population

• 87% live outside their tribal statistical areas, 60% live in urban areas
  • 574 federally recognized tribes, ~60 state recognized tribes
  • 324/574 tribes have a reservation

• 27% of the population is under 18

• States with largest # of AI/AN: AZ, CA, OK, NM, TX, NC, AK, WA, SD, NY

Intersectionality

Total Population of Native Americans in the U.S. (n=9,667,079)

- American Indian and Alaska Native alone (n=3,717,135)
- American Indian and Alaska Native in combination with one or more other races (n=5,939,944)

Source: United States Census Bureau, 2020 Decennial Census
## Overview of AI/AN Health

<table>
<thead>
<tr>
<th></th>
<th>American Indian/Alaska Natives</th>
<th>Non-Hispanic Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>Had at least a high school diploma: 84.4%</td>
<td>Had at least a high school diploma: 93.3%</td>
</tr>
<tr>
<td></td>
<td>Had at least a bachelors (25+): 20.8%</td>
<td>Had at least a bachelors (25+): 36.9%</td>
</tr>
<tr>
<td></td>
<td>Had an advanced degree: 7.6%</td>
<td>Had an advanced degree: 13.9%</td>
</tr>
<tr>
<td><strong>Economics</strong></td>
<td>Median HHI: $49,606</td>
<td>Median HHI: $71,664</td>
</tr>
<tr>
<td></td>
<td>Living at poverty level: 20.3%</td>
<td>Living at poverty level: 9.0%</td>
</tr>
<tr>
<td></td>
<td>Unemployment rate: 7.9%</td>
<td>Unemployment rate: 3.7%</td>
</tr>
<tr>
<td><strong>Insurance coverage</strong></td>
<td>Private insurance (alone &amp; combo): 51.9%</td>
<td>Private insurance (alone &amp; combo): 74.7%</td>
</tr>
<tr>
<td></td>
<td>Medicaid or public only: 42.1%</td>
<td>Medicaid or public only: 34.3%</td>
</tr>
<tr>
<td></td>
<td>Uninsured: 14.9%</td>
<td>Uninsured: 6.3%</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>2020 LE: 78.4 years</td>
<td>2020 LE: 80.6 years</td>
</tr>
<tr>
<td></td>
<td>LE women: 81.1 years</td>
<td>LE women: 82.7 years</td>
</tr>
<tr>
<td></td>
<td>LE men: 75.8 years</td>
<td>LE men: 78.4 years</td>
</tr>
</tbody>
</table>

Challenges and Successes in Indian Health Systems
## All Cause Mortality Rates (2010)

<table>
<thead>
<tr>
<th>Category</th>
<th>AI/AN Rate 2009-2011</th>
<th>U.S. All Races Rate 2010</th>
<th>Ratio: AI/AN to U.S. All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL CAUSES</td>
<td>999.1</td>
<td>747.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Diseases of the heart (Heart Disease)</td>
<td>194.7</td>
<td>179.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Malignant neoplasm (cancer)</td>
<td>178.4</td>
<td>172.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Accidents (unintentional injuries)*</td>
<td>93.7</td>
<td>38.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Diabetes mellitus (diabetes)</td>
<td>66.0</td>
<td>20.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Alcohol-induced</td>
<td>50.0</td>
<td>7.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>46.6</td>
<td>42.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Cerebrovascular diseases (stroke)</td>
<td>43.6</td>
<td>39.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>42.9</td>
<td>9.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>26.6</td>
<td>15.1</td>
<td>1.8</td>
</tr>
</tbody>
</table>
Missing Data

Racial/Ethnic Disparities in Exposure, Disease Susceptibility, and Clinical Outcomes during COVID-19 Pandemic in National Cohort of Adults, United States

McKaylee M. Robertson, Meghan G. Shamsunder, Ellen Brazier, Mekhala Mantravadi, Rebecca Zimba, Madhura S. Rane, Drew A. Westmoreland, Angela M. Parcesepe, Andrew R. Maroko, Sarah G. Kulkarni, Christian Grov, and Denis Nash


Main Article

Table 1

Demographic and socioeconomic characteristics of communities, households, and SARS-CoV-2 epidemiology for Chasing COVID study participants, stratified by race and ethnicity, United States, March 28–April 20, 2020*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>Hispanic or Latino/a</th>
<th>Black non-Hispanic</th>
<th>Asian/Pacific Islander non-Hispanic</th>
<th>White non-Hispanic</th>
<th>Other non-Hispanic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,740</td>
<td>1,308 (19.41)</td>
<td>899 (13.33)</td>
<td>465 (6.00)</td>
<td>3,846 (57.06)</td>
<td>222 (3.30)</td>
<td></td>
</tr>
</tbody>
</table>

**DATA GENOCIDE:**

1. The elimination of Indigenous people in data resulting in the non-fulfillment of treaty and trust responsibility due to “lack” of data on urban and rural tribal communities.

2. Embedded structural racism in data systems that results in non-collection and/or non-reporting of Indigenous people’s race and ethnicity.

3. Lack of data being used as an excuse to not allocate appropriate resources to urban and rural tribal communities perpetuating chronic health disparities.

**UIHI’S DEFINITION:**

1. Reclaiming the Indigenous value of data collection, analysis, and research.

2. Data for Native people, by Native people.

3. Recognizing the inherent strength of Indigenous people.

**WHAT IS DECOLONIZING DATA?**
FOR OUR ALLIES, AKA THE DECOLONIZING DATA HOMIES

1. Acknowledgement of harmful data practices coupled with healing, restoration, and reparations.

2. Strengths-based data collection, analysis, and dissemination.

3. Protective community and cultural factors measured and weighted against disparities and gaps.

4. Community governance every step of the way (collection, analysis, dissemination).

5. Accurate data reporting of race and ethnicity.

6. Embedded accountability of entities for collection of race and ethnicity.

7. Disaggregation of data by race, ethnicity, and multiple races.

8. Undoing STEM education disparities.

9. Exploring and refining small populations methodologies.

10. Acknowledging community knowledge and investing in data capacity as informed by the community.

While colonial institutions cannot be decolonized, non-Indigenous organizations and people can work to achieve data equity and justice.

IN THE CONTEXT OF DECOLONIZING DATA, OUR VISION FOR THE FUTURE OF ALL NATIVE DATA METHODOLOGIES INCLUDES:
## COVID-19 in Indigenous Communities

<table>
<thead>
<tr>
<th>Rate ratios compared to White, Non-Hispanic persons</th>
<th>American Indian or Alaska Native, Non-Hispanic persons</th>
<th>Asian, Non-Hispanic persons</th>
<th>Black or African American, Non-Hispanic persons</th>
<th>Hispanic or Latino persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases(^1)</td>
<td>1.6x</td>
<td>0.8x</td>
<td>1.1x</td>
<td>1.5x</td>
</tr>
<tr>
<td>Hospitalization(^2)</td>
<td>2.5x</td>
<td>0.7x</td>
<td>2.1x</td>
<td>1.8x</td>
</tr>
<tr>
<td>Death(^3)</td>
<td>2.0x</td>
<td>0.8x</td>
<td>1.6x</td>
<td>1.7x</td>
</tr>
</tbody>
</table>

COVID-19 in Indigenous Communities

- Issues of overcrowding, making social distancing more difficult
  - 16% of households in tribal areas and 10% in urban areas overcrowded compared to 2% of all U.S. households
- Underfunded and under resourced health care
  - In 2017, IHS spent $4,078 per person, compared with $9,207 spent per capita by the U.S. health care system overall
- Lack of clean water or adequate sanitation
  - 48% of households on Indian reservations do not have clean water or adequate sanitation.

COVID-19 in Indigenous Communities

Vaccination Successes

• Prioritization of elders, language keepers, and culture bearers

• Over 2.4 million doses administered. Approximately 4 million doses distributed.

• By May 2021, 70% of the Navajo Nation, 95% of the Blackfeet Nation in Montana, and 70% of the Sac and Fox Tribe in Mississippi had been fully vaccinated.

• In March 2021, The Cherokee, Chickasaw, Osage, Choctaw and Citizen Potawatomi Nations have expanded their vaccination eligibility to the general public, include Native and non-Native Oklahomans.
  • At the time OK was in stage 3, so the general public was not eligible for vaccination yet


COVID-19 in Indigenous Communities

Percent of Total Population that has Received 1 or More COVID-19 Vaccine Doses by Race/Ethnicity, April 5, 2021

Based on 53% (56.5 million) of vaccinations with known race/ethnicity:

- Hispanic: 9%
- Black: 12%
- Asian: 16%
- White: 19%
- Native Hawaiian or Other Pacific Islander: 26%
- American Indian or Alaska Native: 32%

NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic, other groups are non-Hispanic.

HEALTH CARE SPENDING

National Average, 2018
$11,172 (CMS)

Incarcerated Population, 2016
$8,602 (GAO)

Indian Health Service, 2017
$4,078 (IHS)

Urban Indian Organizations, 2019
$700 (estimate)
ADVANCE APPROPRIATIONS FOR INDIAN HEALTH SERVICE
Advance Appropriations for the Indian Health Service

• Appropriations for IHS are organized into three accounts
  • Indian Health Services
  • Indian Health Facilities
  • Contract Support Costs
• Indian Health Services is the largest account.
• Over 60% of IHS’s budget is provided to Indian tribes or tribal organizations.
Resiliency

Self-determination

Integration of culture into healthcare
- Art therapy
- Substance use prevention and recovery programs
- Traditional medicine

Inclusion of descendants and state-recognized AI/AN
About NIHB & NCUIH
NIHB Commitment to Working with Tribal Governments

- Supports and respects tribal sovereignty and self-determination
- Tribal consultation
- Government-to-government partnership
What We Do

- Represents 574 federally recognized Tribal governments
- Support initiatives that address the chronic underfunding for the Indian health system
- Project Firstline introduced healthcare infection control to NIHBI’s portfolio and enabled us to build the capacity of frontline Tribal healthcare workers and infection control officers
Infection Control Gaps In Tribal Facilities

• The COVID-19 pandemic highlighted long-standing gaps in infection control knowledge and practice in Tribal healthcare settings.

• These gaps reflect:
  • health inequities experienced by AIANs
  • disparities in infection control expertise
  • gaps in training, mentorship, and education
  • lack of understanding in educational approaches for healthcare workers
  • framing of infection control as a combination of rules, policies and procedures while recognizing different languages and distinct cultures.
INFECTION CONTROL IS THE...

Actions we take...

Systems we put in place...

Culture of shared responsibility we develop...

...To prevent people from getting infected
NIHB Project Firstline

- Steering Committee
- Mentorship Program
- Scholarship Available
- Learning Community (webinars/discussions)
- On-line self paced learning modules
- Job-aids
- Webpage
Partners

- Association of American Indian Physicians
- Dental Infection Prevention & Safety Association (OSAP)
- Indian Health Service (IHS)
- 12 Tribal Epidemiology Centers (TECs)
- American Medical Association
- Johns Hopkins University, Center for Indigenous Health
- University of Arizona
- Arizona State University
- National Council of Urban Indian Health
Tribal Steering Committee

• Provides NIHB with input and guidance on issues affecting the health of AI/AN nations

• Allows for exchange of information on public health issues in Indian Country
  • Identify urgent public health needs
  • Discuss collaborative approaches

• Assist with developing and/or adapting existing materials to inform Tribal health professionals about important components of IPC

• Composition:
  • 6 delegates from federally recognized tribes
IPC Scholarship Opportunity

- Scholarships for Tribal Infection Control Officers and Health Officials
- May be used for online infection control training courses
- May also be used to complete either the Association of Professionals in Infection Control and Epidemiology's (APIC) training courses, the Certification Board of Infection Control and Epidemiology's (CBIC) certification exam, or the Certified in Dental Infection Prevention and Control (CDIPC) exam
- https://www.surveymonkey.com/r/V2TXSJ5
Learning Community Webinars

Facilitate peer learning community webinars for frontline public health professions to provide ongoing skills building, technical assistance, and discussion.

• Upcoming Webinars
  • July 31, 2024
  • August 7, 2024
  • October 16, 2024
  • October 18, 2024
  • December 4, 2024
Educational Materials

- Job aids and factsheets
- Online training modules
- Development/adaptation of AI/AN curriculum
- Response Plans
- IPC Messaging
- Technical Assistance
- Resource Dissemination Plans
App, Messaging, and Website
Regional Institutes

Completed Institutes

- April 28, 2021 (virtual)
- May 10, 2022 (virtual)
- July 19-20, 2022, in Rapid City, SD
- February 28-March 1, 2023 in Seattle, Washington
- May 5, 2023, in Anchorage, Alaska
- September 11-12, 2023, in Sante Fe, New Mexico
- September 19-21, 2023, Tribal Infection Control Boot Camp in Vancouver, Washington*
- May 20, 2024, during 2024 National Tribal Health Conference
NIHB Project Firstline’s Accomplishments

• 1,070+ learners have enrolled in NIHB Infection Control Webinar Series earning a 900+ contact hours.

• 1,200+ people have registered for workshops, Institutes, and Ask Me Anything (AMA) discussion sessions.

• 87% of webinar participants in the series reported having improved understanding & 93% of participants would recommend the webinars.

• NIHB Project Firstline disseminated $300,000 in subgrantee funding to 8 partner organizations.
Partnerships
Moving Forward

- Further expand Project Firstline’s audience reach with culturally appropriate educational products and materials (website, YouTube, newsletters, etc.)

- Improve surveillance data for AI/AN communities

- Workforce development - internships or mentorships programs for AI/AN students

- Identify and understand Tribal healthcare workforce training needs and knowledge gaps to (surveys/focus groups/listening sessions)

- Integrate infection control into formal educational curricula for all healthcare facility staff

- Enhance sustainability through increased cross-sector collaborations
More info: Visit nihb.org
The National Council of Urban Indian Health (NCUIH) is a national non-profit organization devoted to the support and development of quality, accessible, and culturally-competent health and public health services for American Indians and Alaska Natives (AI/ANs) living in urban areas.

NCUIH is a national organization advocating for the 41 Title V Urban Indian Organizations (UIOs) under the Indian Health Service (IHS) in the Indian Health Care Improvement Act (IHCIA)
What is NCUIH?

Including the 70% of Native Americans and Alaska Natives who live in urban settings.
About NCUIH

Our Impact

NCUIH’s critical work accomplishes the following unmet needs:

• Brings Urban and Tribal leaders together to establish a continuous flow of communication and collaboration
• Cultivates and coordinates relationships between UIOs and major mainstream health research centers and universities
• Creates awareness among mainstream media outlets
• Fosters political and managerial leadership among urban AI/AN youth
• Establishes connections between the urban AI/AN population and private foundations, corporations, and donors
Project Firstline at NCUIIH
The COVID-19 pandemic highlights gaps in IPC knowledge and skills in healthcare settings nationwide.

Spring 2020

Fall 2020
The CDC launches the Project Firstline collaborative

September 20, 2020 – September 29, 2021
Grant Year 1

September 30, 2020 – September 29, 2021
Grant Year 1

September 30, 2022 – September 29, 2023
Grant Year 3

September 30, 2023 – September 29, 2024
Grant Year 4

IPC Champions - Subawards

11 UIOs funded

Highlights
- IPC Program Reviews
- IPC Panel Discussion
- Montana UIO Collaboration
- Learning Management Systems
- UIO Spotlights
Digital Media Products

LEAD BY EXAMPLE AND STOP THE SPREAD OF GERMS

Use appropriate PPE!

Clean high-touch surfaces, like doorknobs, regularly.

Clean your hands and keep them healthy!

Tip for Healthy Hands:
- Use hand sanitizer
- Wash hands
- Keep nails short
- Wash and dry

National Indian Health Board
Digital Media Products (cont.)

**TRANSPORTATION IPC CHECKLIST FOR UIOS**

<table>
<thead>
<tr>
<th>BEFORE TRIP</th>
<th>DURING TRIP</th>
<th>AFTER TRIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor both your client’s and your own health and symptoms. If you’re feeling sick, follow your facility protocol.</td>
<td>Wear masks and sit as far apart as possible if the client has respiratory symptoms.</td>
<td>You and the client should use hand sanitizer when getting out of the vehicle.</td>
</tr>
<tr>
<td>Replenish supplies (alcohol-based hand sanitizer, PPE, cleaners, and disinfectants).</td>
<td>When possible and appropriate, improve ventilation, for example, open the windows.</td>
<td>If you suspect any IPC concerns or become symptomatic, inform your supervisor and follow protocols.</td>
</tr>
</tbody>
</table>
| Clean and disinfect high-touch surfaces such as seat belts, door handles, and steering wheel. | Safety Tips
Read and follow the disinfectant label.
Wear gloves when you clean.
Keep your hands and vehicle clean. | Clean and disinfect the vehicle upon arrival at the final location. Be cautious of anything that may have been left behind. |
| You and the client should use hand sanitizer when getting in the vehicle. | Refer to your facility protocol for additional guidance. | Want more information? Reach out to your supervisor or scan the QR code: |

This project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services under grant No. 5U58DP006013. The opinions expressed in this material are those of the author(s) and do not necessarily reflect the views of the National Indian Health Board. The information provided is for educational purposes only and is not a substitute for medical advice or treatment.
NCUIH Native Healthcast
National Council of Urban Indian Health

7 Episodes
18 Guests
9 Streaming Platforms

Where We’ve Been and Where We’re Going
Hosted by Vickie K. Oldman (Diné)

Dr. Donald Warne
(Oglala Lakota)

Highlighting Young Native Voices in Health
Hosted by Vickie K. Oldman (Diné)

Breanna Wheeler
Diabetes Self-Management Training Specialist
Dakota

Dakota Black Hawk
Diabetes Self-Management Training Specialist
Dakota

Elora Ascher
(Diné)

Faith Bowman
Diné

INFECTION CONTROL

Highlighting Frontline Voices in Health
Hosted by Vickie K. Oldman (Diné)

United American Indian Involvement, Inc.
Native American Lifelines, Inc.
Community of Learnings

2 Series (6 Trainings)

Weaving Resilience into IPC for UIOs
1. Reinforcing Key IPC Actions During Flu Season: Addressing Gaps in UIO IPC Training Programs
2. Reflections on Burnout & IPC at UIOs: A Storytelling Approach
3. IPC in Offsite & Virtual Care Settings at UIOs

IPC for Distinctive UIO Care Settings
1. IPC in Urban Indian Outreach/Referral Settings (CEUs)
2. IPC in Urban Indian Behavioral Health Settings (CEUs)
3. IPC in Urban Indian Primary Care Settings
Partnered with American Medical Association EdHub to launch a NCUIH microsite to host CEU eligible trainings.

LMS for non-CEU trainings as well (podcast).
IPC Fellowship

Provided Native American students with the opportunity to increase the work being done in urban Native public health.

Highlights
- Fellows 2020-2023
CALLING ALL UIO WORKERS!

The National Council of Urban Indian Health (NCUIH) is recruiting all UIO workers to participate in a PhotoVoice project.

To apply and learn more, go to https://ncuih.org/community-health/project-firstline/

Indigenous staff are strongly encouraged to apply. Participants will be compensated for their participation.

All UIO staff are eligible to participate.

This project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $125,784.00 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS, or the U.S. Government.

Highlights
Ethical Review
Rooted in Indigenous Knowledge

5 Participants
3 Urban Indian Organizations
Closing
The Indian Health Service, Tribally Operated Facilities, and Urban Health Programs are all distinctly different pathways through which healthcare is delivered to AI/AN people.

(A) True

(B) False
Why are advanced appropriations necessary for Indian Country?

Reduce the negative impact of government shutdowns. 0%

Prevent short-term stopgap measure. 0%

Allows for better planning of healthcare services 0%

All of the above 0%
What projects can you see your organization collaborating with NIHB or NCUIH on?

Nobody has responded yet.

Hang tight! Responses are coming in.
Miigwech
Kutâputunumuw
Thank You
Yá'át’ééh
liohbwana
Pidamayayapi
Contact Information

National Indian Health Board
• Audrianna Marzette, Public Health Policy and Programs Manager, amarzette@nihb.org
• Tyrone Peterson, Infectious Disease Associate, tpeterson@nihb.org

National Council of Urban Indian Health
• Zoë Harris, Public Health Associate, zharris@ncuih.org
• Evey Maho, Director of Technical Assistance, emaho@ncuih.org
• Alyssa Longee, Public Health Manager, alongee@ncuih.org
Nobody has responded yet.

Hang tight! Responses are coming in.
What will you take away from this presentation?

Nobody has responded yet.

Hang tight! Responses are coming in.
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