TESTING NINE CRITICAL SUCCESS FACTORS FOR TRIBAL SELF-GOVERNANCE IN HEALTH CARE IN THE UNITED STATES

A Thesis presented in partial fulfilment of the requirements for

a Doctor of Philosophy in Public Health

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Wellington, New Zealand.

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"No right is more sacred to a nation, to a people, than the right to freely determine its social, economic, political and cultural future without external interference. The fullest expression of this right occurs when a nation freely governs itself".

Joseph De La Cruz - Quinault Indian Nation, U.S. (1937 - 2000)

ABSTRACT

This study examines a Critical Success Factor (CSF) Framework for Tribal Self-Governance (TSG) in health care, drawing on the experiences of Native American and Alaska Native Tribes in the United States. The research aims to validate, refine and critique this framework to support Indigenous development, including Tribal Self-Governance and self-determination in Aotearoa/New Zealand.

The study employed a mixed-methods approach, comprising documentary analysis, observation, literature review, and expert interviews (n=10). Member-checking interviews with U.S. Tribal Self-Governance practitioners provided additional validation. A deductive analytical framework based on the author's original CSFs guided the analysis, which broadly followed the U.K. National Centre for Social Research's Framework Analysis Model.

Results confirm the validity of the nine-factor CSF Framework, with refinements to sequence, content and structure. The factors were reorganized into three sets/stages: commitment and initiation, operationalization, and sustainability to suggest a preferred order for those embarking on the Tribal self-governance developmental journey. The research process led to redefining the factors and prioritizing them based on assessment of their relative importance and member feedback.

While no major omissions were identified by the research process, a critical analysis of study data provided some cautions and contextual issues for practitioners and governors to be aware of when implementing the framework.

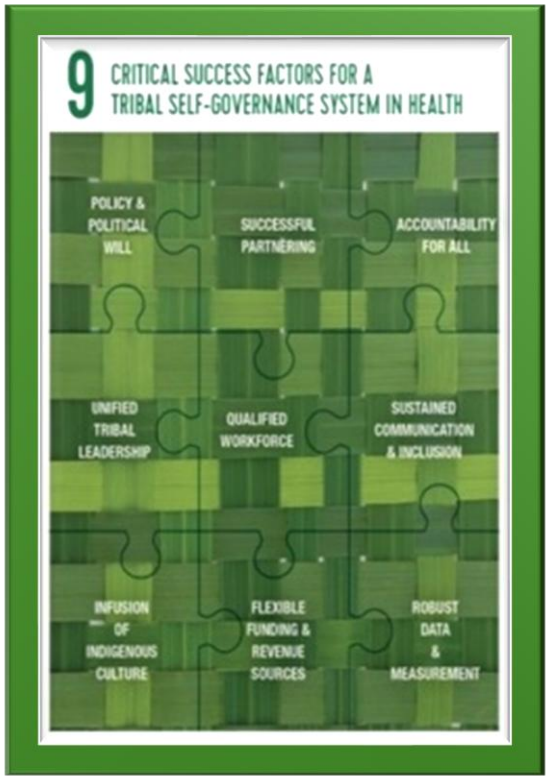
The refined CSF Framework aligns favourably with Kaupapa Māori principles, and an implementation plan for the New Zealand context is proposed. This research contributes to our understanding of effective Tribal Self-Governance models and their potential application in diverse Indigenous contexts, including for indigenous Māori in New Zealand.

Visual Abstract

Original Framework

Validated Framework

*Observation, participation and analysis of Tribal Self-Governance in action, over 12 years

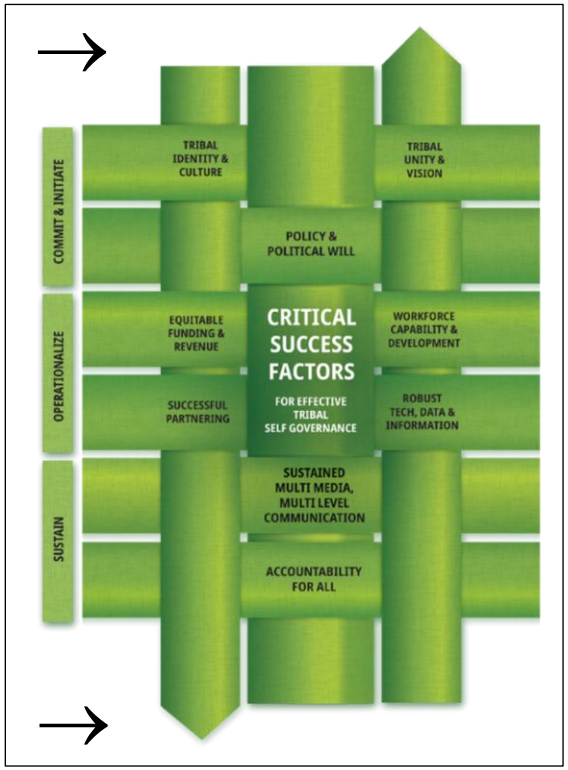


*Member checking interviews – 10 tribal and federal experts;

*Document and Literature Analysis

*Framework Analysis

*Critical Analysis



PERSONAL STATEMENT

Ko Titiokura te maunga

Ko Te Ngarue te awa

Ko Ngāti Tu te hapu

Ko Tangoio te Marae

Ko Ngāti Kahungunu te iwi

Ko Tākitimu te waka

Ko Tararua te maunga

Ko Hokio te awa

Ko Ngāti Pareraukawa te hapu

Ko Ngatokowaru te Marae

Ko Ngāti Raukawa te iwi

Ko Tainui te waka

Ko Mākeo te maunga

Ko Waiaua te awa

Ko Ngāi Tamahaua te hapu

Ko Opape te Marae

Ko Whakatōhea te iwi

Ko Mataatua te waka

Ko Mara Andrews taku ingoa.

I am also proud to identify my English heritage through my Mum. Her family is originally from Torquay in south England, and they emigrated to New Zealand in the early 1900s.

I was born in Wellington New Zealand to a Māori father and a Pākehā mother, and we moved when I was young to Napier in Hawkes Bay on the east coast of the North Island.

After leaving school, I worked for the Māori Land Court; the Māori Trust Office; the Iwi Transition Agency and Te Puni Kokiri. In my many roles in these departments I had the benefit of working alongside exemplars in the art of working with Māori at Iwi, hapū and Marae, landowner and whānau levels. I had the privilege of working directly for a few high-profile Māori leaders, many of whom still today remain in prominent positions across the country. This 20-year plus period laid the foundations for being involved in all and everything Indigenous.

During the 1990s I worked for the former Central Regional Health Authority (RHA) which was later merged with three other RHAs in New Zealand to form the Health Funding Authority (HFA) which managed Vote: Health nationally. The HFA funded health and disability services across the country with Crown-owned hospital entities, community-based service providers and primary care practices. While at the HFA I spent time leading a Māori health team and later I transferred to a National Strategy Manager position for several personal health portfolios including child health, maternity services, and primary care. I was involved in several national strategy design and implementation projects and built my knowledge of how the complex health system works. This time was a time of blending my foundational Māori knowledge with health system knowledge.

It was during this latter period that, in 1999, I was nominated by my Chief Executive for, and awarded, a World Health Organisation (WHO) Fellowship which funded a six to 12-month study in a chosen overseas location. I decided to undertake a study tour of the United States and Canada to learn about Tribal governance, management and delivery of Indigenous health services led by Native

Americans (U.S.) and First Nations (Canada). I organized and undertook a seven-month tour of both countries visiting several Native American Reservations and First Nations Reserves, observing and learning about their approach to Indigenous-led governance and delivery of health services for their Tribal members. My goal from studying this topic was to bring back lessons for Māori health development in Aotearoa particularly around governance of health care, since Māori organizations at the time were primarily involved in providing health and disability services – but not governing or funding them. My investigations revealed that many challenges were being faced for Tribes who had opted into Self-Governance arrangements. Not least of all, a major challenge was (and still is) a shortfall in funding to meet the inter-generational health needs of the populations.

Despite this, Tribes took great pride in knowing they had improved access for Tribal citizens to Tribally-tailored health services and programs incorporating much higher levels of local Indigenous culture, language, art and design, along with more Indigenous workforce, models of care and innovation. These features, however, were often so successful that enrolments of patients increased dramatically in some cases, and high levels of previously unmet and undiagnosed needs surfaced (e.g., undetected Acquired immunodeficiency syndrome (AIDS) cases).

The knowledge I gained, and people I had met who hosted me during that study tour, led me to continue to be very interested in Tribal Self-Governance (TSG) in health care. I felt at the time that there were many lessons that could inform potential developments in New Zealand – even though we had a very different political structure and underlying constitutional foundation. I had also made many new friends and peers who worked in the field of Indigenous health, and I made it a point to sustain those connections as the years progressed.

In the year 2000 I left the HFA, when it was disestablished by a new Government and replaced with 21 District Health Boards, to form an Indigenous consultancy company called Kāhui Tautoko Consulting Ltd (KTCL). I have worked for KTCL as a Senior Consultant since July 2000 when it

was formed, to this day. KTCL has provided consultancy services for Māori and Pasifika organizations in Aotearoa as well as ministries, agencies and departments of Government, including District Health Boards. In 2008 an opportunity presented itself to work in Canada in the Indigenous health care field and I moved there in May 2008, forming a subsidiary of KTCL based in Vancouver. I lived there from 2008-2020 and provided consultancy services for the Indigenous First Nations organizations as well as Government agencies including local Health Authorities. I transitioned from Canada back to New Zealand in 2020.

During that 12-year period spent living in North America, I continued to informally observe the progress being made in TSG of health care by Native American and Alaska Native Tribal organizations, attending conferences and reconnecting with colleagues I had met during my WHO Fellowship. My residence in Vancouver Canada and proximity to the United States (U.S.), enabled me to increase my physical engagement in TSG activity through conference attendance and many site visits to Native communities and reservations.

Over the years I strengthened my existing relationships, and developed several new relationships, with Tribal health leaders, from the local community level, to regional, State and national level – some who worked locally advocating for their citizens, and some who worked nationally advocating for Tribes. I gathered many reports, presentations, research articles, policy papers and media articles, and held many discussions with Indigenous colleagues and friends in the U.S. Some of what I learned was highly relevant to the consulting services we were offering in First Nations health care in Canada, as they too were interested in elevating their governance of health programming and increasing control through establishment of a First Nations Health Authority in British Columbia.

By 2017 I had started to categorize the wealth of information I had gathered over the period since my 1999 WHO Fellowship visit, and this theming led to me developing a framework of nine factors that I considered were critical to the success of TSG. I became very interested in validating these factors

so that the information could be used within an Aotearoa setting, with a level of reliability, to inform further work in increasing Māori governance and management of health care. At the prompting of Professor Sir Mason Durie, a long-time respected Māori health leader in Aotearoa whom I had come to know over the years, I enrolled and was confirmed in the PhD program at Massey University in late 2018.

I have continued as a Senior Consultant for KTCL during this period – finding time to complete this Thesis to meet my PhD requirements, while maintaining my relationships and connections with friends, leaders and respected colleagues in Canada and the U.S. I will always admire and in many ways, envy, the level of control that Tribes have over their own health services and programs in the U.S. and the impact that this has had on their identity, pride, growth and influence in the health system in the U.S. I aspire one day to support Iwi Māori to also increase their level of governance and control of health care funding and delivery for Māori and other New Zealanders in Aotearoa. I am convinced that increased Māori governance of health care services will provide significant benefit not just for Māori but for many other New Zealanders as well, because the approach is fundamentally whānau-centred and based on benefitting the collective.

MIHI / ACKNOWLEDGMENTS

I must firstly thank and acknowledge my whānau. My parents, siblings, daughters, and grand-daughter – for encouraging me to keep going when I felt this was overwhelming; for letting me have time at my computer to get this work done and giving me that space; to my whānau at Kāhui Tautoko Consulting who kept the work going while I extracted myself to get some writing done; and to my extended whānau from my hapu and Iwi, ngā mihi nui.

To Professor Sir Mason Durie who first encouraged me to embark on completing a PhD when I was living in Vancouver and telling me 'you have the time while you are here, make the most of it.' You provided me with an opportunity to complete this work and give something back to the many Native American and Alaska Native people who had shared so much with me during my years of living in North America. Being able to gift this story back to the people who originally provided it, has enabled me to express the reciprocity that us as Indigenous people treasure so deeply.

To my amazing supervisors, Professor Chris Cunningham, Hope Tupara and Marg Wilkie – thank you so much for the incredible patience and guidance you provided, and the constant encouragement. Just when I felt I wasn't good enough to get this done – you would remind me that I was doing okay. Those much-needed words of confidence and support really helped me to carry on.

I would like to thank and acknowledge everyone who has contributed time, perspectives, and materials to this thesis. To all my friends, colleagues and Indigenous brothers and sisters in the United States – I give my deepest appreciation. I thank you for the many years of friendship, for allowing me to participate in your conferences and workshops; for hosting me at various site visits as far back as 1999, and for being so open with sharing your knowledge; for being so willing to provide information, materials, and resources – thank you. For all the discussions and for answering my questions, I am extremely grateful.

To those who agreed to be interviewed for this work, I especially thank you for giving me your time and being so free and frank with your knowledge, your stories and your experiences. You are all true leaders and your Self-Governance journey over the past 30 – 40 years has been an inspiration even though you have had (and still do have) many challenges and obstacles to overcome. We as Indigenous people of Aotearoa have much to learn from you - and your stories and experiences will undoubtedly help us to consider possible new ways forward.

To my colleagues and friends from the Indian Health Service – thank you. The fact you have achieved what you have in the realm of Self-Governance, despite your significant pressures of under-funding, workforce pressures and significant service delivery challenges, the number of current self-governing Tribes in health care is a testament to the work you have done to help make that happen.

Finally, to the team at Massey University including Professor Chris Cunningham, Hope Tupara and Marg Wilkie, along with the student support team; the ethics team; and the staff who continually share information and learning opportunities with students. For the Pūrehuroa Postgraduate Award, I am deeply grateful.

Completing this work has helped me to bring together over 20 years of learning in one place. I could not have done it without this entire support crew!

Signature 

Ngā mihi ki a koutou katoa

Mara Andrews

28 February 2025

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GLOSSARY AND TERMS USED

IMPORTANT NOTE: This thesis employs United States (U.S.) spelling conventions, reflecting its focus on a subject matter rooted in the U.S. The majority of data and literature sources are derived from U.S. contexts, and the participants involved in the research are also from the U.S.

ACRONYM	DEFINITION
AI/AN	American Indian / Alaska Native
AFA	Annual Funding Agreement: An agreement signed each year between a Tribe and a Federal government entity which sets out the PSFAs to be transferred to the Tribe and those PSFAs to be retained by the government
ANTHC	Alaska Native Tribal Health Consortium
BIA	Bureau of Indian Affairs [a division of the DOI]
DHHS	Department of Health and Human Services
DOI	Department of the Interior
GAO	[U.S.] Government Accountability Office
IHCIA	Indian Health Care Improvement Act 1976
HIS	Indian Health Service [a division of the DHHS]
ISDEAA	Indian Self-Determination and Education Assistance Act 1975, amended 1994 and 2000
ITU	Anagram used to describe the three forms of service delivery to AI/AN communities I = Indian Health Service delivery T = Tribal delivery (including self-governing Tribes). U = Urban service provider delivery (such as Seattle Indian Health Board)
NCAI	National Congress of the American Indian
NIHB	National Indian Health Board
PSFAs	Programs, services, functions, and activities (of government agency)
SCIA	Senate Committee on Indian Affairs
SGCETC	Self-Governance Communication and Education Tribal Consortium
TSG	Tribal Self-Governance
TSGAG	Tribal Self-Governance Advisory Group [to the Director of IHS]
USET	United South and Eastern Tribes.

KEY TERMS	DESCRIPTION
638(s)	The passing by Congress of the Indian Self Determination and Education Assistance Act 1975 allowed Indian Tribes and Tribal organizations to acquire increased control over the management of Federal programs that impact their members, resources and governments. These agreements are referred to as "638 compacts and contracts or '638s.'" **Self-**

KEY TERMS	DESCRIPTION
	Determination contracts are authorized under the 1975 Indian Self Determination and Education Assistance Act. **Self-Governance compacts** are made possible by 1994 amendments to the 1975 Indian Self Determination and Education Assistance Act or Public Law 93-638 or P.L. 93-638 (U.S. Department of the Interior, n.d.). So '638' refers to transferring the responsibility and funds for a PSFA (see below definition) from the federal government to the tribe. By law the government must give the tribe the same amount of money it spent itself on the PSFA, making this a dollar-for-dollar transfer. Tribes are also able to be paid for administrative overhead costs, called Contract Support Costs (CSC). These costs include personnel administration, training, and facility support cost, among others.
Compact Agreement	A 'compact agreement' is described as "an agreement, treaty, or contract most often applied to agreements among states or between nations on matters in which they have a common concern." (Lehman & Phelps, 2005) Under ISDEAA **Self-Governance compacts** are a legally binding and mutually enforceable written agreement that affirms the government-to-government relationship between a Self-Governance Tribe and the United States consistent with the Federal Government's trust responsibility and statutory and treaty obligations to Indian Tribes and such other terms as the parties intend to control from year to year. A compact is not a typical procurement contract of purchaser and provider of service. It signals a nation to nation or government to government relationship.
Federally Recognized Tribe (FRT)	Bureau of Indian Affairs (BIA) Definition: A federally recognized Tribe is an American Indian or Alaska Native Tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs [BIA]. Furthermore, federally recognized Tribes are recognized as possessing certain inherent rights of self-government (i.e., Tribal sovereignty) and are entitled to receive certain Federal benefits, services, and protections because of their special relationship with the United States (Indian Affairs, 2020).
Inherent Federal Function ***sometimes known as*** **Inherently Governmental Function *or* Residual**	This definition is important as it defines functions of Federal agencies unable to be transferred to Tribal control under a contract or compact agreement. Two primary definitions exist for this term (Service, 2014). Definitions of Inherently Governmental Functions under Procurement Law and Guidelines: • Statutory Definition: "a function so intimately related to the public interest as to require performance by Federal Government employees" (Federal Activities Inventory Reform Act of 1998). • Policy Definition: "An activity that is so intimately related to the public interest as to mandate performance by government personnel" (Office of Management and Budget Circular A-76, 2003). The purpose of defining these functions is to clarify what functions can and cannot be contracted by Federal agencies. While there are further elaborations to the definition the above provides a simple description for the purposes of this report.
Native American / Tribes	The term "Tribe" interchangeably with "American Indian", "Native American", and "Tribal nations." These terms refer to "any Federally-recognized governing body of an Indian or Alaska Native Tribe, band, nation, pueblo, village, or community that the Secretary of Interior acknowledges to exist as an Indian Tribe under the Federally Recognized Indian Tribe List Act of 1994. "Federally recognized Tribes are recognized as possessing certain inherent rights of self-government (i.e., Tribal sovereignty) and are entitled to receive certain Federal benefits, services, and protections because of their special relationship with the United States." (Indian Affairs, 2020)

KEY TERMS	DESCRIPTION
Plenary Powers Doctrine	A plenary power or plenary authority is a complete and absolute power to act on a particular issue, with no limitations. In challenging the Federal Government plenary power over Native American affairs, in the case of United States v. Kagama (*United States v. Kagama,* 1886 as cited in Justia, 2019) the Supreme Court found that Congress had complete authority over all Native American affairs.
PSFAs **Programs, services, functions, and activities**	This is a comprehensive description and stock-take of the Programs, Services, Functions, and Activities of a Federal agency to provide a basis for negotiating compact agreements and Tribal shares. A complete picture of the PSFAs of the IHS for instance is done at a service area, regional and central level to determine the value of PSFAs and to determine what might be inherently federal functions. A full PSFA manual is produced and constantly updated by the agency to ensure the latest appropriations are updated in the budgets within the document. It provides line-item detail for all accounts and categories. This is shared with Tribes and allows Tribes and Tribal organizations to be more fully informed to make decisions regarding available resources and programs to best meet the health care needs of their respective Tribal communities. Title V of The Tribal Self-Governance Amendments of 2000, Public Law 106-260 specifically states under this Section that Congressional reporting shall include: "(C) the funds transferred to each Self-Governance Indian Tribe and the corresponding reduction in the Federal bureaucracy; (D) the funding formula for individual Tribal shares of all headquarters funds, together with the comments of affected Indian Tribes or Tribal organizations, developed under subsection (c); and (E) amounts expended in the preceding fiscal year to carry out inherent Federal functions, including an identification of those functions by type and location;"
Purchased and Referred Care	Care provided by a non-ITU (IHS/Tribal/Urban service provider) to which patients are referred and paid for by an ITU (mostly specialist and inpatient). Typically, a self-governing Tribe would hold the budget for referred care and make the referral to another health facility, and then be billed for the care.
Retrocession	The voluntary return of a program operated under an Annual Funding Agreement by a Tribe to the Federal government before the agreement expires.
Tribal Share	The proportionate share of IHS or BIA administrative funds associated with each Federal program. These funds are commonly held at the agency, service unit/service area and central / headquarter office level. Administrative dollars represent PSFAs that are not residual and that a Tribe is entitled to receive under a Self-Governance Compact. The Tribal Share Methodology is an allocation formula that is used to calculate a Tribe's or Tribal organization's share of a PSFA or portion thereof for Federal agency dollars. A Retained Tribal Share are those funds that are available as a Tribal share but determined by the Tribe under the AFA to be left with the Federal agency to administer.
Trust / Fiduciary Responsibility (Trust Doctrine)	The responsibility of the Federal government to honor treaties, compromises, and other bound agreements by inheriting the expectation to honor those agreements for the best interests of the Tribes and its members. Bureau of Indian Affairs (BIA) Definition: The Federal Indian trust responsibility is a legal obligation under which the United States "*has charged itself with moral obligations of the highest responsibility and trust*" toward Indian Tribes (Seminole Nation v. United States, 1942). This obligation was first discussed by Chief Justice John Marshall in Cherokee Nation v. Georgia (1831). Over the years, the trust doctrine has been at the center of numerous other Supreme Court cases, thus making it one of the most important principles in Federal Indian law. The Federal Indian trust responsibility is also a legally enforceable fiduciary obligation on the part of the United States to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of Federal law with respect to American Indian and Alaska Native Tribes and villages (Indian Affairs, 2020)

CHAPTER 1: INTRODUCTION

1.1. Current State and Introduction to Thesis Topic

This thesis is about Tribal Self-Governance (TSG) in health care for Indigenous people and communities in the United States (U.S.) and the primary purpose is understanding the critical success factors that should exist, or be addressed, to make the TSG model work for Tribes. Understanding these factors is important to Tribal organizations in the U.S. as 39% of the 574 Tribes have not yet transitioned to TSG. Those Tribes have elected to have the Federal government continue to govern and deliver their health care, and they do so under the mantle of self-determination rather than self-governance. The work is also important as it may help inform decision-making here in Aotearoa New Zealand as Indigenous Māori continue to consider an increased role in governance and decision-making in health care (and other areas) locally. These developments are especially significant following the release of the Waitangi Tribunal WAI 2575 Hauora Report (Waitangi Tribunal, 2019) and the establishment of Iwi Māori Partnership Boards established under legislation ("Pae Ora (Healthy Futures) Act," 2022)[1].

A secondary purpose for this thesis may be the information it can offer to other Indigenous Tribes or other Indigenous jurisdictions, including those Tribes in the U.S. who have elected not to move into the Self-Governance model yet; our Native Hawai'ian Polynesian brothers and sisters who do not have a TSG policy applicable to them (yet); and our Indigenous Australian neighbors.

1.2. Rationale and Reasons for the Research

At the time of writing this thesis 352 (61%) of the 574 Tribes in the U.S. including Alaska had self-governing arrangements for health care programs and services for their communities (Self-Governance Communication and Education Tribal Consortium, 2018a). This majority of Tribes

[1] Although at the time of writing parts of the Pae Ora Act were under repeal and the Māori Health Authority had been disestablished.

now manage and control their own health care while the Indian Health Service (IHS), a division of the U.S. Department of Health and Human Services (DHHS) historically responsible for delivering health care to Native Americans and Alaska Natives, has simultaneously downsized as Tribes assume control of their programs, services, functions and activities (formally known as PSFAs) in their Tribal areas. In some areas, the Federal IHS office has completely closed due to the transfer of all of their PSFAs to self-governing Tribes in their operating area.

Any Tribe who meets the TSG due diligence criteria may self-determine to assume Self-Governance over their health care PSFAs through a 'Compact Agreement'. A compact agreement (versus a contract agreement) is typically an agreement between sovereign states. Under the TSG legislation and policy, when a Tribe elects to take control, the Indian Health Service must initiate a process of transferring control of its' PSFAs to those Tribes – and simultaneously downsize their operation and presence in that community.

The alternatives to TSG are that Tribes can self-determine that the IHS continue to provide all or some of the IHS health services for their community, or Tribes may enter a typical procurement-type contract to deliver some programs and services themselves through funding from the IHS. These are known as 'direct-service' Tribes in the health care system rather than self-governing Tribes.

From my observations and peer discussions to date, there are several reasons that Tribes may choose to decide that the IHS continue providing the Tribe it's health care. For instance, the Tribe might consider that they do not have the capacity to meet the TSG criteria; they may feel there is too much risk for them in taking on TSG from the IHS due to the budget constraints and under-funding of IHS; they may be satisfied with the current arrangement and feel they are receiving good care from the IHS; they may have many Tribal citizens already working in the IHS facility who are happy in their employ; or they may have other priorities for TSG (e.g. Bureau of

Indian Affairs housing programs for instance) and have identified that the assumption of governing health care is a future strategic priority.

1.3. Proposed Critical Success Factor Framework for Tribal Self-Governance in Health Care

Since 1998 I have been gathering a range of information on TSG of health care in the U.S. Tribal Self-Governance emerged as a particular interest for me as a Māori Health Manager in the New Zealand health system in the 1990s. I wanted to see what other Indigenous people were doing that was successfully transforming health care, and how they were increasing the Indigenous voice and role at governance, management and delivery levels in the health system. I was equally interested in how this impacted health experiences and outcomes for Indigenous people.

I gathered and sorted the information I had collected over the years into categories based on what was emerging as essential components of the TSG model that were frequently discussed, analysed, focused on or advocated for – among and by Tribes. Several important factors continued to consistently emerge in different settings over multiple years. Often these factors were the core themes of Tribal self-governance conferences and Tribal planning sessions. I landed on what I determined were nine Critical Success Factors (CSFs) that appeared to support an effective TSG 'system'. What emerged was a practice-based (and likely strengths-based) CSF framework, shaped by information observed, gathered and reviewed over the 20-year period since my WHO Fellowship.

From these observations, I proposed that each factor needed to actively co-exist with the others to make the TSG model sustainable, especially since TSG has been in place in the U.S. since the early 1990s. I also determined that each factor was inter-connected while being itself inherently complex.

This thesis presents the research on whether my assumptions about the criticality of these nine factors, and their co-existence in a framework, are valid.

The thesis is intended to take a systems view of TSG and the conditions needed to create an environment where TSG for Indigenous Tribes can operate successfully. The framework potentially provides a comprehensive approach to establishing and sustaining TSG in the U.S. health care system. Each critical success factor relates to empowering Tribes to self-govern and manage their health care systems effectively. The framework I have developed is a 9-dimensional set of connected factors that I ***hypothesize*** are critical for supporting and sustaining the Tribal Self-Governance of the Tribe's own health system. The framework is comprehensively described in Chapter 4.

1.4. Parameters for this research

I have researched the 'system' that enables and supports TSG – not the health outcomes for patients or communities emerging from TSG arrangements. This thesis will not look at the specific impact that TSG in health care has on health outcomes or health measures for the population. One of the reasons for this is that robust information is not readily available on pre- and post- health status of populations of Tribes who engaged in the TSG policy. In fact, this lack of evidence on specific measures of health status in a pre- and post-TSG environment was noted by one of my research participants as a gap that they identified many years later after TSG legislation was passed. It is now an issue they are working to address.

1.5. Research Aims and Analytical Approach

1.5.1. Research Aims and Research Questions

The aim of this research is to validate and refine a framework of critical success factors for Tribal Self-Governance of health care in the United States. The initial framework developed by me will serve as the starting point for this research. The research will address the following research questions:

1. To what extent do the identified critical success factors align with the experiences of Tribes currently engaged in health care Self-Governance?
2. How do Tribal leaders and health administrators perceive the relative importance and applicability of each factor in the framework?
3. What additional factors, if any, do Tribes identify as critical to the success of self-governed health care systems that I might have missed?
4. What contextual and environmental factors should be taken account of for the CSFs individually and collectively?

The U.K. National Centre for Social Research's Framework Analysis Model (Gale et al., 2013) forms the basis of the analytical phase.

1.6. Philosophical Underpinning

A Kaupapa Māori approach (an Indigenous Māori way of being and doing) underpins all work that I undertake in both my work role and as a researcher (Rewi, 2014; Smith, 1997, 2017). Whether I am working directly with Indigenous communities or working with organizations providing services for Indigenous people, or working with Indigenous people from other Nations/countries, I aim to be true to myself and to be authentic. The standards I operate from come from an approach based on tikanga Māori (traditional Māori concepts of what is correct) as that is who I am and how I was raised. I do not try to be anything but myself as a sign of respect to the Indigenous people that I connect with. I honour the fact that when in the lands of other Indigenous people, I am manuhiri (a visitor) to their territories. Therefore, I show respect and humility to my hosts and the people of those territories.

I am committed to privileging the Indigenous voice of research participants and sharing their stories as comprehensively as possible, so as to show respect for our natural Indigenous story-telling style. For this reason, some of the quotes used in this Thesis may be considered quite long.

This was intentional to privilege the Indigenous voice while recognizing that often the contextual story was important to understand the point being made. It is how we as Māori also communicate when we are naturally 'storytelling' in our engagement with each other.

To demonstrate my commitment for tikanga Māori, as part of my work we developed internal standards that guide the work that we do. I apply these same standards to my role as a consultant and as a researcher. The Kāhui Tautoko Consulting Kaupapa Māori framework of standards (Kahui Tautoko Consulting Ltd, 2024) guides my relationships and engagement processes to ensure that practices are robust and culturally safe. The framework is described in Chapter 3.

1.6.1. Methods

This work is primarily qualitative research. I did not collect financial, patient or service level data from Tribes or the Indian Health Service, although during the research I drew on quantitative information reported in documents that I reviewed where available.

This study employs a research paradigm that draws upon kaupapa Māori principles while respecting the unique cultural context of Indigenous peoples in the United States.

The study utilizes a multi-method approach to data collection:

- **In-depth interviews:** Semi-structured interviews conducted with key informants, guided by culturally appropriate protocols that emphasize relationship-building (whanaungatanga) and respect (manaakitanga) and reciprocity;
- **Member checking:** A structured approach to validate findings with participants, ensuring accurate representation of their perspectives and experiences;
- **Literature and document analysis:** A comprehensive review of relevant academic and grey literature, with particular attention to Indigenous-specific resources.

The analysis of these data is guided by the NatCen Framework Analysis Method (Gale et al., 2013), which provides a systematic and transparent approach to qualitative data analysis. This

method is particularly well-suited for applied policy research and allows for both inductive and deductive analysis. As a practitioner in community development this approach suits my approach to the work I do every day.

The Framework Method involves five key stages: familiarization with the data; identifying a thematic framework (in this case the original CSF Framework); applying the framework to the data; creating a matrix of data summaries; and finally, interpretation. The results of implementing this framework analytically are presented in Chapter Five.

By combining Indigenous research principles with the rigorous Framework Analysis Method, this approach aims to produce culturally grounded, methodologically sound research that contributes to improving self-determination in health care governance, and ultimately Indigenous health outcomes.

1.7. Structure of Thesis

Chapter 1 introduces the thesis.

Chapter 2 provides a background to the setting for this research, which is the environment for Tribal Self-Governance in the U.S. This chapter provides the necessary context for Tribal America and the relationships with governments over time***, particularly in the context of the provision of health care to Tribal members***. The chapter introduces and describes two key contextual descriptions:

- a brief overview of Native American Tribes and their relevant Indian [health] history, policies and legislation, and;
- a description of Tribal Self-Governance in the United States in health care, including definitions of Self-Governance and Tribal Self-Governance (TSG), and how they inform a systems approach.

This overview aims to provide the historical and legal backdrop against which TSG arrangements are negotiated and operationalized in the U.S.

Chapter 3 presents the methodology and methods for the research. There is an Indigenous research foundation to this study from a kaupapa Māori perspective, which is further supported by the application of my own Kaupapa Māori Standards framework. The methodology describes three phases: **Phase I** of the broader research project focusses on the development of the original framework, **Phase II** is the validation process used to test my research aim and questions; and **Phase III** is where I updated and improved my CSF framework following the validation process.

Chapter 4 presents the Critical Success Factor framework. This framework is my original work, and a full description of its development – *including the methods used* – is given as it is not available elsewhere. A full description of my CSF framework and each of the nine factors is provided. Relevant literature and supporting documents (up to 2017) and the numerous in-person observations that led to defining these nine factors, have been incorporated into this chapter.

Chapter 5 is the first results section and presents the results of the research process which has validated the framework. It provides an analysis based on the use of a Deductive Framework Analysis method using triangulated data sources: interviews, literature/document review and direct observations. The validation timeline from 2018 to 2023 (although interrupted by the Covid-19 pandemic) allowed for further documents to be reviewed in this phase, as well as further observations from visits conducted during that period.

Chapter 6 revises the initial CSF framework in light of the findings in Chapter 5. Following the validation process, the initial CSF framework was both narratively and visually updated. The new framework identifies the relative importance and sequencing of the factors and the visual representation of the connectivity of the CSFs is enhanced to demonstrate this

sequencing. The dual factor set of the original framework has become a three-factor set: commitment & initiation factors, operationalization factors, and sustaining factors. Each of the critical success factors has been re-worded to better reflect the substantive changes which the research process determined were necessary to provide greater clarity. A critique of the overall framework and its philosophy is provided.

Chapter 7 describes the possible implementation of the revised framework in a New Zealand setting. This chapter outlines an assessment of lessons with specific reference to recent health system reviews and Waitangi Tribunal findings that relate to Self-Governance and sovereignty. There are also recommendations for further work to maximize the learnings from this research.

***Chapter** 8* synthesizes the study's findings, evaluating the initial hypothesis of nine critical factors for successful Tribal Self-Governance in health care in the U.S. The validation process largely confirmed this hypothesis while refining the framework's factor importance, sequencing, clarity, and relevance. The chapter concludes by proposing strategies to advance Iwi Self-Governance in health care in Aotearoa/New Zealand, leveraging insights from the U.S. context.

The thesis then provides a number of Appendices with additional information.

CHAPTER 2: NATIVE AMERICA AND TRIBAL SELF-GOVERNANCE

2.1. Chapter Description

This Chapter provides a necessary description of the context, history, status and political environment within which this research is set. First, it provides an examination of Native American Tribes, focusing on the associated policies and legislation. It starts with a definition and description of Tribal U.S., with Federal and State recognition. This overview serves to establish the historical and legal backdrop against which TSG is situated. Second, the chapter elucidates the concept of Tribal Self-Governance within the United States health care system.

This dual focus allows for a nuanced understanding of the complex interplay between historical factors, policy and legal developments, and contemporary governance structures among Alaska Native and Native American populations.

2.2. Definition of Tribes

The United States (U.S.) Constitution vests Congress, and by extension the Executive and Judicial branches of government, with the authority to engage in relationships with the Tribes, thereby firmly placing Tribes within the constitutional fabric of the U.S. (Library of Congress).

The U.S. Constitution recognizes three sovereigns: the Federal government, State governments, and Indian Tribal governments. As sovereigns, Tribes pre-date the U.S. (pre-Columbian), and retain rights of Self-Government ("Worcester v. Georgia," 1832). When the U.S. was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs ("Morton v. Mancari," 1974). The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification ("American Federation of Government Employees, AFL-CIO v. Trump," 2003; "Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation," 1976;

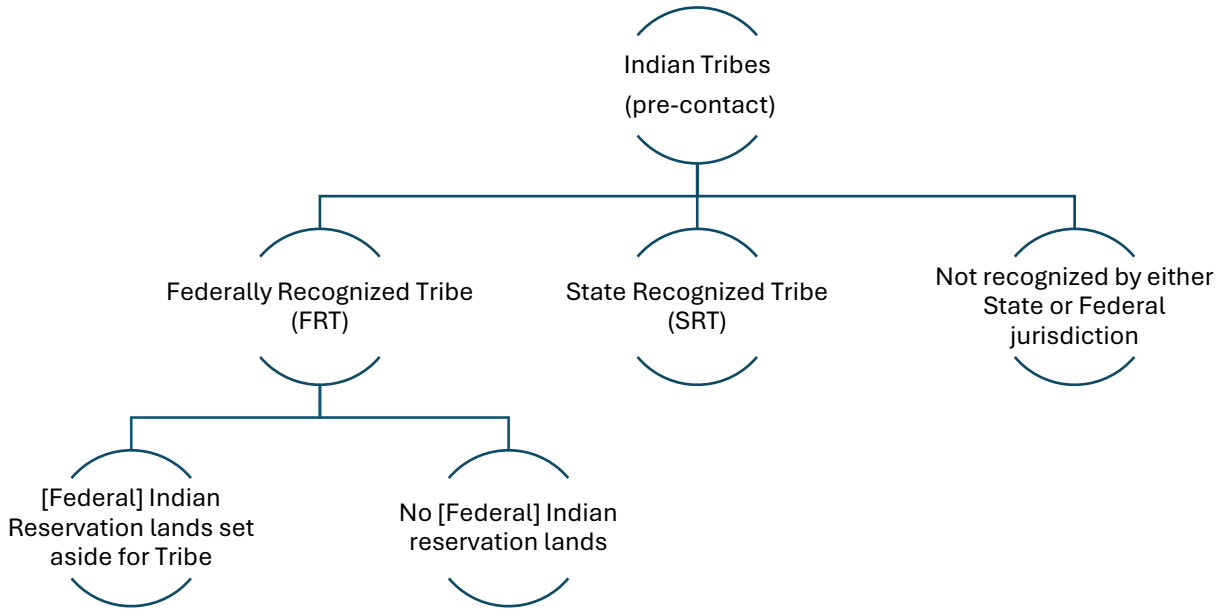
"Morton v. Mancari," 1974; "United States v. Antelope," 1977; "Washington v. Washington State Commercial Passenger Fishing Vessel Association," 1979).

2.2.1. Federally Recognized Tribes

In the U.S., an Indian Tribe or Native American Tribe refers to a clan, Tribe, band, nation, chapter, or other group or community of Indigenous peoples (National Congress of American Indians, 2020). Modern forms of these entities are often associated with land or territory of an Indian reservation.

Not all Tribes have status as 'Federally Recognized Tribes', some only have 'State-Recognized' status. Other Tribes are unrecognized because they no longer exist as an organized group or because they have not completed the certification process established by the government entities in question (Bureau of Indian Affairs, nd). The following diagram that I developed aims to illustrate the different status that Tribes can potentially hold where authorized to do so.

Figure 1: The Official Status of Tribes in the U.S.



A Federally Recognized Tribe (FRT) refers to a legal recognition in U.S. law given to a Native American and Alaska Native Tribe (Dean, 1971). The definition does not include Native

Hawai'ian Indigenous people, in the State of Hawai'i, who currently do not have a standing process for Federal recognition. According to the Bureau of Indian Affairs (Indian Affairs, 2020) there are currently 574 federally recognized Tribes in the U.S.

2.2.2. State Recognized Tribes

For State-Recognized Tribes, each State determines its own rules. State Tribal recognition does not confer the same benefits as Federally Recognized Tribes; it acknowledges Tribal status within the State but does not guarantee funding from the state or federal government (National Conference of State Legislatures, 2016).

2.2.3. Indian Reservations

According to the Bureau of Indian Affairs (BIA) in the U.S. there are three types of reserved Federal lands: Military, Public, and Indian (Bureau of Indian Affairs, nd).

Figure 2: Location map of American Indian and Alaska Native Reservations in the U.S.

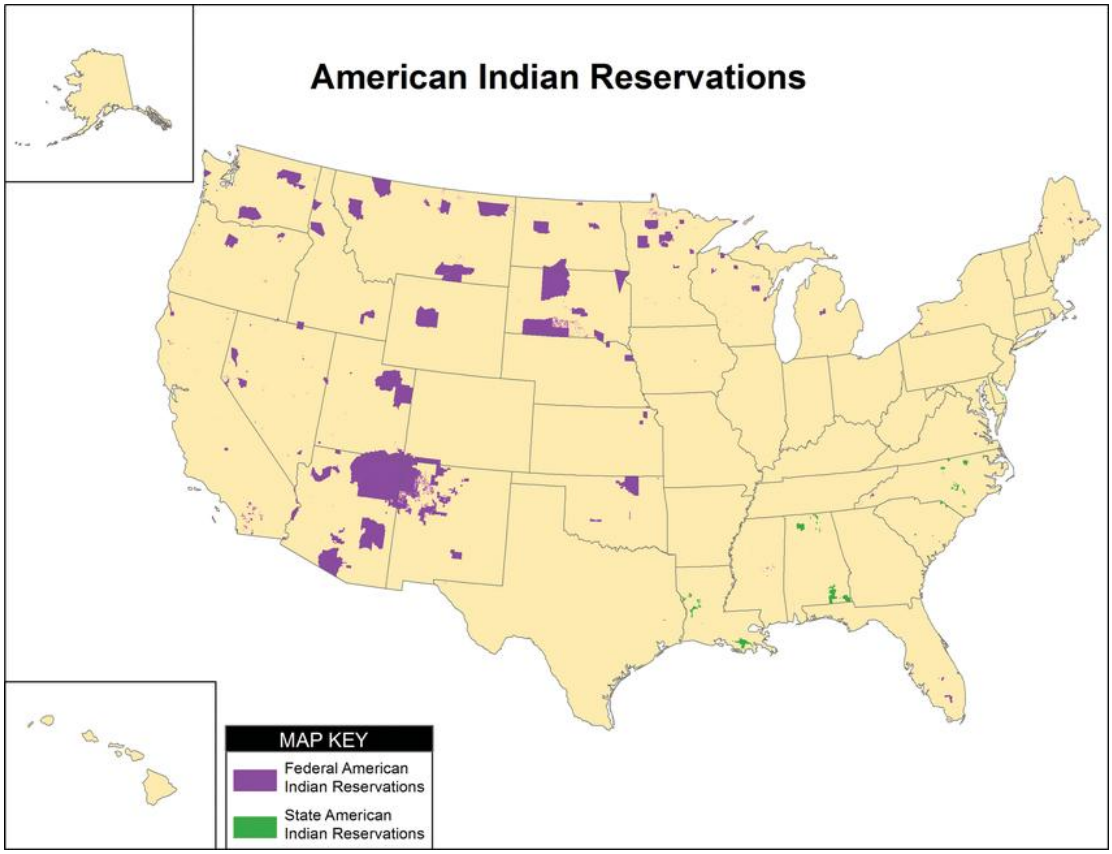


Illustration source: (Warne & Wescott, 2019)

A Federal Indian reservation is an area of land reserved for a Tribe or Tribes under treaty or other agreement with the U.S., executive order, or Federal statute or administrative action as permanent Tribal homelands. Approximately 56.2 million acres are held in trust by the U.S. for various Indian Tribes and individuals (see map below). The largest Indian Reservation is the 16 million-acre Navajo Nation Reservation located in Arizona, New Mexico, and Utah.

2.3. The Native American and Alaska Native Population

The Native American and Alaska Native populations in the United States are significant and have been growing steadily over recent years. Here are some key statistics:

2.3.1. Population Size

As of 2021, there were approximately 9.7 million people who identified as American Indian or Alaska Native (AI/AN), either alone or in combination with other races. This represents about 2.9% of the total U.S. population of 329.5 million (National Council on Aging, 2024).

2.3.2. Breakdown by Identification

In 2020, the Census Bureau counted 9,666,058 people who identified as AI/AN, which includes those who identified as AI/AN alone and those who identified as AI/AN in combination with one or more other races (Congressional Research Service, 2024).

2.3.3. Distribution

About 78% of Native Americans live outside of reservations, with many residing in urban areas. In 2020, 87% of all AI/AN people identified in the Census lived outside of Tribal statistical areas, and 60% lived in metropolitan areas (National Council on Aging, 2024).

2.3.4. Tribal Affiliations

There are 574 federally recognized American Indian and Alaska Native Tribes, although not all recognized Tribes have a reservation. Some Tribes have more than one reservation, while others share reservations or have none (United States Census Bureau, 2022).

2.3.5. Geographic Concentration

The states with the highest percentage of AI/AN populations include Alaska, Oklahoma, New Mexico, South Dakota, Montana, and North Dakota. Alaska has the highest percentage, with 21.9% of its population identifying as AI/AN (National Council on Aging, 2024).

2.4. Indian policy and legislative history impacting on the health care system today

The U.S. has a lengthy and complex history when it comes to Indian health policy and legislation. This section will focus on key policy and legislative events that have had the greatest influence on health-related Self-Governance arrangements that exist today.

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the U.S. in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples ("United States v. Winans ", 1905). Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the U.S. has “moral obligations of the highest responsibility and trust.” ("Seminole Nation v. United States," 1942; "Worcester v. Georgia," 1832).

Congress established the Indian health care system and passed legislation (IHCIA) ("Indian Health Care Improvement Act," 2010). In the IHCIA, for instance, Congress found that “Federal health services to maintain and improve the health of the Indians are consonant with, and required by, the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”. In the Indian Self-determination and Education

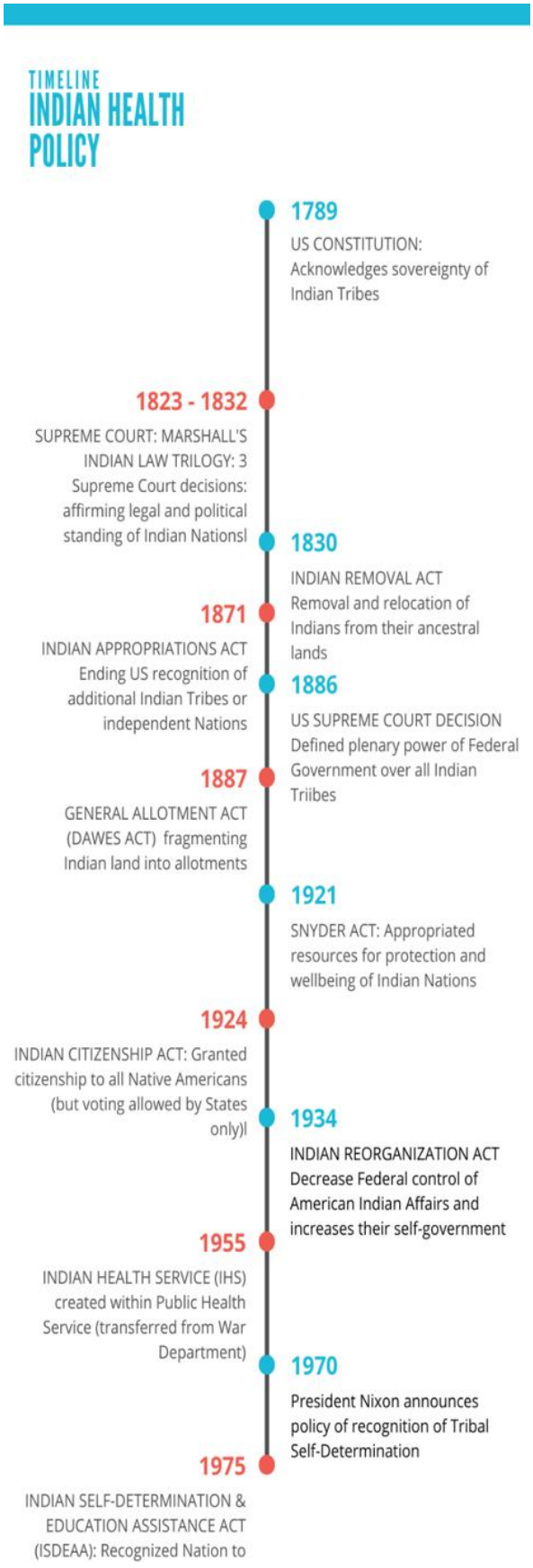
Assistance Act (ISDEAA) ("Indian Self-Determination and Education Assistance Act," 1975) Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service.

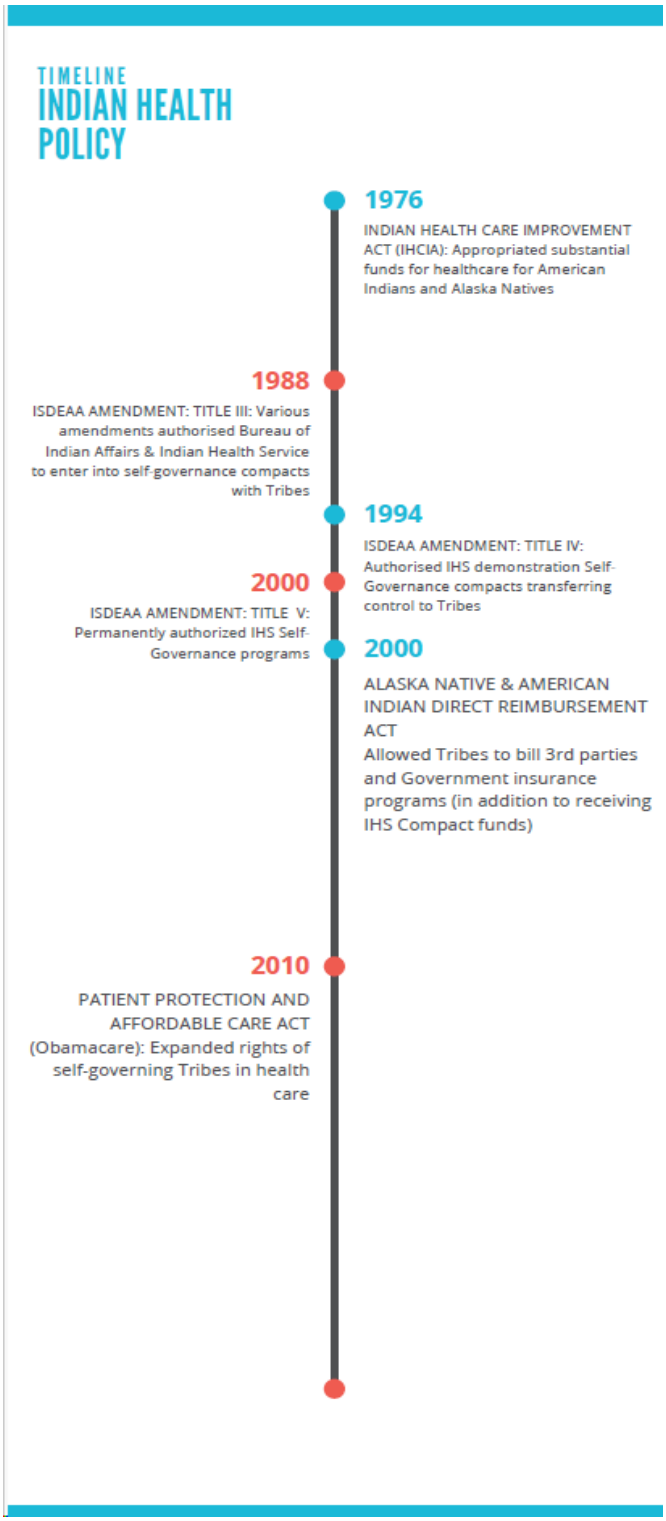
The Self-Governance Communication and Education Tribal Consortium (SGCETC) one-page summary of the Constitutional Foundation for Indian-specific Health Care legislation (Indian Health Service, 2017, p.2) further states that:

> *"Congress has full constitutional authority to legislate with regard to Indian health care and should continue to promote Tribal sovereignty and uphold the government-to-government relationship between the United States and Tribes in fulfillment of its trust and legal responsibilities."*

The timeline below highlights a 132-year period of significant oppression of Indian Tribes after the 1789 U.S. Constitution came into effect, up until the 1920s when the 1921 Snyder Act triggered a shift toward recognizing the sovereignty of Tribes. By 1970 the then President Nixon accelerated that recognition through his announcement of a new Federal Indian policy to recognize the right for Tribes to self-govern their own affairs. Following that announcement, a number of laws were enacted which gradually shifted more and more control to Indian Tribes (refer to Appendix B for further descriptions of these Laws).

Figure 3: Timelines of key Indian health policies, decisions and legislation





2.5. Overview of Tribal Self-Governance in Health

2.5.1. Introduction

In the U.S. most programs and services that affect the everyday lives of Native Americans and Alaska Natives have been overseen and delivered by various agencies of the Federal government. It is only since the passing of Self-Governance legislation enacted in 1975 that Tribes have had the opportunity to take that responsibility from the Federal Government to manage health care (and other programs) for themselves.

This thesis is intentional in including a lot of 'thick description' and extensive quotes from members so it can be better understood by readers from other jurisdictions, and to provide transparency to help with identification of potential similarities and differences. Examples have also been provided for each factor to enhance understanding.

There is an absence of literature on the success or effectiveness of Tribal Self-Governance as a 'system', however there are many articles that focus on one or more of some of the factors I have identified – be it the legal framework, a policy challenge, workforce or data-related issue (Indian Health Service, 2016c; Kunesh, 2019; G. D. Strommer & S. D. Osborne, 2014). The primary measure of the success of Self-Governance that has been reported is the level of uptake by Tribes and growth in number of Tribes and dollar value of the IHS transfers since the TSG program began (Kunesh, 2019).

Most literature that I was able to review has been produced by those with the greatest vested interest in the model - and therefore the greatest bias - Tribes themselves or their agents, *and* the Federal government. There are many academics, researchers and historians who reflect on Indian policy and legislation and its impact of Tribes and Governments or have discussed specific subjects such as the expression of sovereignty or economic impacts – and only a few have focused on the entire 'system' of TSG and all the pieces that it takes to sustain it in today's environment. Very

little literature exists that evaluates the success of TSG in health care objectively and independently and provides a description of the factors that have enabled the TSG system to achieve such a high level of uptake among Tribes. There was much work done previously to develop an evaluation approach for the original demonstration pilots for Self-Governance (Westat, 2003) however, which includes some direction from Tribal leaders on what is important to them.

There is, however, literature available on Indigenous models of Self-Governance as a general construct, which provides both lessons and cautionary advice on implementing and sustaining successful Self-Governance (Cornell & Kalt, 2010). Some of the literature is applicable to specific factors, and some applies to the framework as a whole (Kunesh, 2019; G. Strommer & S. Osborne, 2014; G. D. Strommer & S. D. Osborne, 2014). While not always specific to health care, the evidence is still relevant in its application to the framework proposed within this thesis.

2.5.2. Defining Self-Governance

Self-Governance has been defined (Esmark & Triantafillou, 2009; Rasmussen, 2011; Sørensen & Triantafillou, 2009) as: *'the ability of a person or group to exercise all necessary functions of regulation without intervention from an external authority'.*

Self-Governance is also closely related to the concept of self-determination which refers to the idea that groups have the right to govern themselves, to make decisions about their own lives and to determine their own future and political status without outside interference (Hannum, 2023).

2.5.3. Tribal Self-Governance as a Government-to-Government Relationship between Tribes and the U.S. Government

Self-Governance – as described in policy and legislation of the U.S. – confirms that Native American and Alaska Native Tribes are sovereign nations with inherent authority to govern and protect the health, safety, and welfare of Tribal citizens within Tribal lands and territories. This authority established a unique legal and political relationship with the Federal government.

According to the National Congress of American Indians (NCAI) report on the status of Self-Governance arrangements at the Indian Health Service, the 574 (as of June 2020) sovereign Tribal nations have a formal nation-to-nation relationship with the U.S. Government (National Congress of American Indian, 2020; National Congress of American Indians, 2018).

Further, the NCAI state that:

> *the U.S. Constitution recognizes that Tribal nations are sovereign governments. Hundreds of treaties, along with the Supreme Court, the President, and Congress, have repeatedly affirmed that Tribal nations retain their inherent powers of self-government. Treaties, executive orders, and laws have created a fundamental contract between Tribes and the United States. The treaties and laws create what is known as the Federal "trust responsibility" to protect both Tribal lands and Tribal self-government. (National Congress of American Indians, 2018, p14)*

The status of Tribes was defined as far back as 1832 by Chief Justice Marshall in his statement:

> *Indian Nations had always been considered as distinct, independent political communities, retaining their original natural rights, as the undisputed possessors of the soil . . . The very term 'nation' so generally applied to them means 'a people distinct from other' ("Worcester v. Georgia," 1832, p5).*

Strommer and Osborne (2014) state that:

> *Today Tribal governments maintain the power to determine their own governance structures, pass laws, and enforce laws through police departments and Tribal courts. Tribal governments provide multiple programs and services, including, but not limited to, social programs, first-responder services, education, workforce development, and energy*

and land management. They also build and maintain a variety of infrastructure, including roads, bridges, and public buildings (G. Strommer & S. Osborne, 2014, p39).

NCAI's report on budget requests to the Federal government (Villegas, 2016) provides further evidence supporting Tribal self-government, stating that Tribes continue to defend their treaty-guaranteed rights and asset their powers of government which emanate from the U.S. Constitution, treaties, acts of Congress and presidential executive orders. Despite Federal policies of removal, relocation, forced assimilation, allotment and termination (Adams, 1995; Cobb & Fowler, 2007; Deloria Jr, 2016; Jacobs, 2014) as highlighted in my timeline above, the continuing viability of Tribal cultures and governments reflects the determination of Indian Tribes to endure as distinct peoples.

2.5.4. Tribal Sovereignty

Aside from various Treaties, Presidential Executive Orders and Supreme Court rulings, the U.S. Constitution of 1789 is the only formal document that acknowledges Tribal governance as a system apart from the American system of federalism (Anderson, 2017). Based upon the wording of the Commerce and the Apportionment Clauses of the Constitution, the relationship between the Federal government and Tribes is one between sovereign nations and exclusive authority over Native American affairs lie with the Federal government, not the state (Ashley & Jarratt-Ziemski, 1999; Ortiz, 2002).

Native American Tribes have been defined as *"sovereign nations within the borders of the United States, who hold a very distinct political and legal position"* (Anderson, 2017). Even though many Tribes have entered into agreements and Treaties with the United States government they have never forfeited their sovereignty and as a result remain *"independent, occupying a position of sovereign immunity"* (Evans, 2001) on U.S. soil. (Wilkins & Stark, 2003) identify that as sovereign nations within another sovereign nation, Native American Tribes face challenges and have

experienced considerable conflicts with the U.S., state and local governments regarding jurisdiction, gaming regulations, natural resources and tax obligations.

(D. Delaney, 2017) recalled the work of Tribal leaders in the 1960s noting that *"against the backdrop of Tribes losing their Federal recognition—and thus their lands, Self-Governance rights, and members—Tribal leaders launched an advocacy campaign that was both desperate and bold."* The American Indian Movement's fundamental goal in their legislative activism was:

> *"not to return to a mystical past in the Federal-Indian relationship where Tribal sovereignty was respected, dismantling the idea that Tribes were ever viewed as sovereign equals. Instead, AIM leaders sought to reimagine the entire Federal-Tribal relationship from the ground up." (Harris, 2014, p319)*

Tribal advocates knew they had to change the language used by both the Federal agencies and within their own documents. Although Tribal leadership began to use the language of Self-Governance and self-determination in the context of Federal law, they never abandoned their demands for Tribal sovereignty. They just foregrounded the need for Self-Governance in a deliberate strategy to gain allies. Thus, the goal of most Tribal leaders was finding a way of wresting substantive decision-making power and control – particularly over financial decisions – from the Federal agencies (Deloria Jr, 2016).

Tribal leaders found that insisting upon the sovereignty of Indian nations over their own lands and peoples was not a tactic that provided concrete solutions to the problems facing their communities; thus, they began to look for alternative methods to achieve their goal. Tribal leaders realized that they had to find a way of gaining control within the legal framework of the United States if they were to limit interference from the Federal agencies (D. Delaney, 2017).

In their paper on the myths and realities of Tribal sovereignty (Kalt & Singer, 2004) noted that:

"Tribes do exercise substantial, albeit limited, sovereignty. This sovereignty is not a set of "special" rights. Rather, its roots lie in the fact that Indian nations pre-exist the United States and their sovereignty has been diminished, but not terminated. Tribal sovereignty is recognized and protected by the U.S. Constitution, legal precedent, and treaties, as well as applicable principles of human rights." [Kalt & Singer, 2004, p3]

(Kalt & Singer, 2004) also identify that, when it comes to defining Indian sovereignty, sovereignty is self-rule, affirming that the "very act of treating is a nation-to-nation form of intergovernmental interaction" and that:

"the resulting treaties did not and do not absorb the Tribes into the United States; rather, the reverse is true. The treaties recognize and preserve Tribal sovereignty: In return for giving up almost all the land in the U.S., the U.S. made promises to the Tribes. It promised to respect their rights over reserved land and to recognize that those lands would be governed by Tribes, not by the state governments. Hence, the term Indian 'reservation'. Those Tribes that did not sign treaties were similarly protected by the doctrine that inherent sovereignty is to be respected by the United States." [Kalt & Singer, 2004, p12]

Until ISDEAA, the attempts by Tribal leaders to retain, or regain, control over Tribal lands and governance had come through arguments of Tribal sovereignty – that as sovereign nations they had the right to govern their territories without interference. After the Kagama ("United States v. Kagama," 1886) and Lone Wolf ("Lone Wolf v. Hitchcock," 1903) decisions, which upheld the plenary power of Congress to make unilateral decisions regarding Tribes and their lands, sovereignty arguments looked fragile. Rather than retread the path of the Indian Reorganization Act and try again to regain control *via* a framework of secondary sovereignty within that of the United States – a path that left Tribes vulnerable to the whims of Congress – Tribal advocates argued that it was time to make United States Federal laws work for them.

When the National Congress of American Indians released the Declaration of Indian Purpose in 1961 (American Indian Chicago Conference, 1961), Tribal advocates reached out to the Kennedy Administration with an innovative idea: Use the government contracting process as a mechanism for transferring control of Federal funds from the Federal agencies to the Tribes through demonstration pilots. By the time President Nixon addressed Congress in 1970 (Nixon, 1970) and called for a pivot away from the termination and relocation policies, Tribes had been running a series of successful Self-Governance contracts through these demonstration projects.

2.5.5. Tribal Self-Determination

In addition to Tribes sitting outside the parameters of the federalist system, differences in culture and identity also influence the interactions between Tribal nations and the U.S. Government. Tribal governance incorporates such issues as Tribal culture, history, social interactions, laws, jurisdiction, and sovereignty; therefore, it is critical to understand why Indian country wishes to retain their ways of governance (Ortiz, 2002). There is indeed a difference between the cultural and traditional aspects of American governance and that of Tribal governance. These differences present very real barriers to conflict resolution between these two governance systems.

2.5.6. Tribal Self-Governance

Tribal governance is a pre-Columbian practice that predates the U.S. Constitution and Federal law (Ronquillo, 2011). There is no other group in the United States for which an analogous model can be provided in terms of cultural identity and Self-Governance, and yet, as some have previously pointed out, there seems to be an absence of academic studies on American Indian Tribal governance in the field possibly most suited for it (Aufrecht, 1999).

Ortiz's article (Ortiz, 2002) is a thorough examination of Tribal governance and public administration in the context of laws and treaties and goes into detail on cases that shaped the current landscape of Tribal relations with the Federal and state governments. Additionally, he wrote on Tribes as sovereign entities, their jurisdiction in both civil and criminal cases, and the special

status of certain Tribes. Ortiz noted that Federal recognition of a Tribe is administered by the Bureau of Indian Affairs under the U.S. Department of the Interior, and may grant additional benefits to Tribes, including federally administered health care and educational programs (Ortiz, 2002).

The Harvard Project on American Indian Economic Development (HPAIED) was founded by Stephen Cornell and Joseph P. Kalt in 1987. It is formally affiliated with the Harvard University Native American Program and has long been housed at the John F. Kennedy School of Government. Through this collaboration, Cornell and Kalt have published numerous research articles and reports on issues in Native American governance and economic development (Begay et al., 1998; Cornell & Kalt, 1987, 1992, 1995, 1998, 2000, 2010; Kalt, 1997; Kalt et al., 2003; Kalt & Singer, 2004; Taylor & Kalt, 2005). The recent volume by the Harvard Project, 'The State of the Native Nations; Conditions under U.S. Policies of Self-Determination' (Perdue, 2009), was published with the intent to survey the state of American Indian nations and communities in the early stages of the 21st century primarily for Federal, state, and local policy makers. Indeed, looking across the more than 560 Tribes that comprise Indian Country, the picture is one of diversity – of societies and cultures, of governments and leadership, or organizations and activities, or socioeconomic status and prospects, and of trends and concerns.

In terms of Tribal governance, recent publications by scholars associated HPAIED (Begay et al., 1998; Harvard Project on American Indian Economic Development, 2008; Jorgensen, 2007) have quickly become the most comprehensive research in American Indian issues in government, economic development, leadership, and other topics important in American Indian communities, including land issues, gaming, international relations, and the environment.

The Congress in Public Law ("Tribal Self-governance Amendment Act," 2000) defines the goal of their Self-Governance policy is to permit an orderly transition from Federal domination of programs and services to provide Indian Tribes with meaningful authority, control, funding, and

discretion to plan, conduct, redesign, and administer programs, services, functions, and activities (or portions thereof) that meet the needs of the individual Tribal communities (D Delaney, 2017). In practice, Self-Governance has two basic parts:

- The transfer of the responsibility for managing Federal programs (and funds) that serve Indians from existing service providers to the Tribes, and;
- Providing Tribes with the broad authority to redesign Federal programs and reallocate Federal resources to more effectively and efficiently meet the needs of Tribal communities.

The Self-Governance Communications and Education Tribal Consortium (SGCETC) is a Tribal-owned entity charged with collecting and disseminating information and education for the Tribes in the U.S. According to the SGCETC *"Self-Governance allows Tribes maximum flexibility to use and redesign Federal dollars associated with assumed programs, services, functions and activities (PSFAs) to meet local community service needs and Tribally-driven priorities."* Emerging from the Self-Governance legislation was an opportunity for Tribes to move beyond procurement-type contracts for delivering services prescribed by the Federal government – to Compact Agreements founded within government-to-government (sometimes referred to as nation-to-nation) relationships (Self-Governance Communication and Education Tribal Consortium, 2018b).

2.6. The Emergence of Tribal Self-Governance through Bureau of Indian Affairs (BIA)

2.6.1. Legislative framework

The authority for Tribal management of federally funded programs was initially provided by Congress under legislation in 1975 ("Indian Self-Determination and Education Assistance Act," 1975) which determined:

- Titles I and II of that Act authorize Tribes to assume management of Bureau of Indian Affairs programs through contractual agreements. From 1975 to the present, Congress

has expanded the opportunities for Tribes to manage their own programs and has increased the degree of Tribal authority and discretion in management;

- Title III, which authorized the Tribal Self-Governance Demonstration Project that allowed Tribes to assume greater control over BIA programs that they managed, including consolidation and re-design of programs to better meet individual Tribal priorities and needs. In 1992, as part of ("Indian Employment, Training and Related Services Demonstration Act," 1992), Congress extended the Title III Self-Governance demonstration to provide for Tribal Self-Governance of Indian Health Service programs;

- Based on the success of these demonstration projects, Congress made Tribal Self-Governance a permanent program within BIA in 1994 (Title IV) and made permanent Tribal Self-Governance of IHS programs in 2000 (Title V).

In 1988, after years of advocacy from Tribes, Congress amended ISDEAA to allow Tribes to assume responsibility for administering the programs, services, functions, and activities (PSFAs) that were previously managed by the Department of the Interior (DOI) through the Self-Governance Demonstration project.

2.6.2. Self-Governance success with the Bureau of Indian Affairs (BIA)

In 2006, then Deputy Assistant Secretary of Indian Affairs (*Statement of George T Skibine Acting Deputy Assistant Secretary – Indian Affairs Department of the Interior at the Oversight Hearing on Tribal Self-Governance* 2006) stated that:

> *"the Department strongly supports Self-Governance as an exercise of Tribal sovereignty and self-determination. Tribal Self-Governance is a framework for progress because it empowers Tribes to prioritize their needs and plan their futures at their own pace, consistent with their own distinct cultures, traditions, and institutions. Many Tribes have*

made this choice, which is demonstrated by the fact that in 2006, the BIA has 91 funding agreements providing services to 231 Tribes, for a total of $300 million, which is a significant increase from a total of $27 million for the funding agreements with seven Tribes made in 1991, the year the program began." [Skibine, 2006, p.1]

Today, under Self-Governance, Tribes have assumed the management of a large number of programs, services, functions and activities (and portions thereof) in the Department of Interior such as roads, housing, education, law enforcement, court systems, and natural resources management (Harvard Project on American Indian Economic Development, 2008).

In addition to administering BIA and IHS programs, Tribes have successfully negotiated funding agreements with the following agencies within the BIA Department: the Bureau of Land Management, the Bureau of Reclamation (e.g. Council of Athabascan Tribal Governments (Council of Athabascan Tribal Governments, nd)), the National Park Service (e.g. Gila River Indian Community (Gila River Indian Community, nd)), the U.S. Fish and Wildlife Service (e.g. Tanana Chiefs Conference (Tanana Chiefs Conference, nd))**,** and the Office of the Special Trustee for American Indians (e.g. Council of Athabascan Tribal Governments)**.** Tribes are typically successful in obtaining these agreements where a compacted program is of special geographical, cultural, or historical significance to them, such as the agreement between the U.S. Fish and Wildlife Service and the Council of Athabaskan Tribal Governments (Office of the Federal Register & U.S. Government Publishing Office, 2004).

Strommer and Osborne articulate the increasing success in transfer of programs from the federal government to Tribes:

"the success of Self-Governance under the ISDEAA is reflected in the remarkable growth of its programs over the years. In 1991, only seven Tribes entered Self-Governance agreements with the BIA, for a total amount of slightly over $27 million. By Fiscal Year

(FY) 2013, 254 Tribes and Tribal consortia entered into 106 funding agreements, operating $432 million in programs, functions, services and activities (G. D. Strommer & S. D. Osborne, 2014, p.50)."

2.7. The Emergence of Tribal Self-Governance through the Indian Health Service

The federal provision of health care for American Indians and Alaska Natives is a constitutional and treaty-based obligation stemming from the trust relationship between the U.S. government and Tribal nations, reinforced through legislation that establishes a framework for Tribal Self-Governance in health care delivery, despite some limitations in implementation. Details are provided in the following section.

2.7.1. Legislative framework – Treaties and Trust

Federal health care for AI/AN is not part of the nation's social welfare program, nor is it insurance. Rather it is a program founded upon the Federal promise to provide health care services to AI/ANs; a Federal promise made in Treaties and authorized by the Constitution (National Indian Health Board, 1998). Creating the Trust Relationship and the duty to provide Indian Health care, taken together, these regularly recited treaty terms reveal a fairly uniform set of promises: Tribes cede their land, and promise peace in exchange for benefits from the Federal government and the right to occupy remaining (or substitute) lands. The treaties, as a compilation, created the trustee-beneficiary relationship between the Federal government and Tribes. Tribes accepted treaty terms under pressure and reluctantly, often seeing no other means for continued survival. Once accepted, however, Tribes rightly and reasonably relied upon the promises of the Federal government to provide benefits and annuities. On many occasions, the Federal government has renewed its promise to provide health care for American Indians and Alaska Natives (National Indian Health Board, 2015; Patel, 2023).

The 1975 legislation (ISDEEA) established the legal framework for Tribes to exercise their inherent right to govern and to protect Tribal citizens, lands, and resources. This legislation saw the Indian Health Service begin to widely contract out to Tribes several of the programs and services that they would normally have delivered themselves (G. D. Strommer & S. D. Osborne, 2014).

Congress amended the Act in 1994 ("Tribal Self-Governance Act," 1994), adding Title IV, which established the permanent Tribal Self-Governance program within the U.S. Department of the Interior. The 1994 amendments authorized federally recognized Tribes to negotiate funding agreements with the Department for programs, services, functions or activities (PSFAs) administered by the Bureau of Indian Affairs (BIA), and in certain circumstances, with other Bureaus of the Department. The 2000 amendment to the Act ("Tribal Self-Governance Amendments Act of 2000," 2000) included Title V, which established permanent Self-Governance authority for the IHS within the Department of Health and Human Services (DHHS). The 2000 amendments also included a new Title VI that provided for a study to determine the feasibility of conducting a Self-Governance Demonstration project in other programs of the Department of Health and Human Services, which has since been completed. Despite this, the DHHS has been reluctant to date to enter into Tribal compacts for other DHHS programs outside of the IHS branch of their department (G. Strommer & S. Osborne, 2014).

2.7.2. Evolution of Health Service Delivery to Tribes

According to a 2003 report (Westat, 2003), health services for the ‘American Indian’ began in the United States War Department through Army physicians who were mainly focused on curbing smallpox in the vicinity of military posts, in order to protect soldiers from infection. In 1849, the Bureau of Indian Affairs (BIA) was relocated from the War Department to the Department of the Interior. By the year 1900 the Indian Medical Service (IMS) as it was known then employed 83 physicians and 25 nurses (Racehorse, 2024).

In 1921, Congress enacted the Snyder Act (U.S. Senate, 1921), which authorized appropriations for Indian health and enabled the Department of the Interior to construct hospital and health facilities on reservations and to deliver minimum health care (Office of the Law Revision Council, 2022). From these appropriations, the BIA created a formal Federal Indian health program that either provided direct care to Indians or relied upon standard public contracts to purchase health care services from local physicians and public hospitals for the benefit of Indians (United States Senate, 2008).

In 1954 the Indian Health Transfer Act ("Transfer Act," 1954) authorized the transfer of all functions, responsibilities, duties and authorities of the Indian health program from the Department of the Interior to the Public Health Service, an arm of the Department of Health, Education and Welfare or DEHW, a precursor to the DHHS. These included responsibilities related to the maintenance and operation of hospital and health facilities, and the conservation of health for Indians. The Indian Health Service (IHS) was transferred from the Department of the Interior to the Public Health Service effective July 1, 1955.

After the transfer of the IHS to the U.S. Public Health Service, Congress doubled the appropriations for the IHS from $18 million to $36 million and appointed Dr. James Ray Shaw as Director. He is quoted as often remarking on a Chinese proverb: *"Tell me, I'll forget; show me, I may remember, but involve me and I'll understand."* (Rhoades & Rhoades, 2014).

He also stated that his top goals were to do things *with* people, not *to* them, and to control tuberculosis. One of the first initiatives of the new director was to secure passage of the Sanitation Facilities Act ("Indian Sanitation Facilities Act," 1959). The law greatly fostered community involvement by requiring that the Public Health Service "consult with and encourage the participation of Indians in the development of sanitation projects" (Indian Health Service, 2009) which stimulated the provision of safe water and waste disposal.

During this era, the proliferation of Tribal and community advisory health boards helped emphasize the health of communities as well as of individuals (Todd, 1982). Collaborations grew among the IHS, Tribes, other federal agencies such as the Centers for Disease Control and Prevention and the National Institutes of Health, and voluntary health organizations such as the American Heart Association.

From 1955 the Indian Health Service continued to plan and deliver health services on reservations for American Indians and Alaska Natives, employing thousands of employees (Managers, Physicians, nurses, hospital staff, environmental and public health officers) to do so. Over the ensuing 20-year period, Tribes continued to advocate for a greater role in governing and delivering health services themselves and for the Federal Indian Health Service to play a diminished role in the day to day lives of communities. This eventually resulted in the passing of the Indian Self-Determination and Education Assistance Act ("Indian Self-Determination and Education Assistance Act," 1975).

2.7.3. Starting with Demonstration Projects

With TSG beginning to expand across the Bureau of Indian Affairs (BIA), the next most logical 'Indian' agency to implement TSG legislation was the Indian Health Service (IHS) – a branch of the Department of Health and Human Services (DHHS). Even though there was proof of the concept evident through the BIA compacting process, Congress agreed only to conduct demonstration pilots for TSG of DHHS programs before committing to it fully.

In 2000 ("Tribal Self-Governance Amendments of 2000," 2000), Congress re-affirmed its commitment to TSG. In the Preamble to the Act, the Congress defined the goal of Self-Governance as:

> *"to permit an orderly transition from Federal domination of programs and services to provide Indian Tribes with meaningful authority, control, funding, and discretion to plan,*

conduct, redesign, and administer programs, services, functions, and activities (or portions thereof) that meet the needs of individual Tribal communities."

The Congress directed the Secretary of Health and Human Services to *"conduct a study to determine the feasibility of a Tribal Self-Governance demonstration project"* (U.S. Department of Health and Human Services, 2003). The Self-Governance Demonstration program was intended to permit a simpler, multiple-program application process and simpler consolidated reporting requirements. Most importantly, the Demonstration program would provide "Tribes with the flexibility to change programs and reallocate funds among programs" to better address specific Tribal community priorities (U.S. Department of Health and Human Services, 2003).

2.7.4. Contracting vs compacting – the 'none, some or all' options facing Tribes

The decision to '638' (compact) a program is a complex one. A Tribe may choose to '638' a part of a program or all of it. For example, a Tribe may:

1. take over a drug and alcohol rehabilitation program while keeping the inpatient hospital under IHS direct control;
2. choose to enter into a regional consortium with other Tribes and together enter into a 638 compact/contract; or
3. choose to 638 an entire facility and its administration. A Tribe may also elect not to 638 any part of a program/service provided by a Federal agency due to administrative concerns.

Each of these decisions are instances of Tribes exercising their self-determination rights and arguably a moment of Tribal sovereignty. However, the ISDEAA itself is not, and was not, conceptualized as a mechanism of Tribal sovereignty, but rather one of protecting TSG *via* contracting.

The courts have not erred by resolving issues arising out of ISDEAA through contract law, nor has Congress erred in treating ISDEAA as a mechanism of Tribal self-determination, but not Tribal sovereignty (D. Delaney, 2017). Indeed, Tribal advocates have been adamant before the courts and Congress that what Tribes would desire from ISDEAA is that they are to be treated as contractors with the full rights and protections normally given. Tribal advocates have shifted the Congressional vision of the full scope of 638 contracting/compacting but have not moved away from that general frame because it provides another avenue for protecting Tribal interests without necessarily invoking Indian law doctrines that may be problematic. The government contracting frame has its own problems, as demonstrated by the ongoing conflict over contract support costs, but those issues are new to the debates around Federal Indian policy for the Tribes (Feldesman Tucker Leifer Fidell LLP, 2023; G. D. Strommer & S. D. Osborne, 2014).

2.7.5. Tribal Self-Governance success with the Indian Health Service (IHS)

Program success is reported by the Indian Health Service on their website which identifies the increasing number of Tribes choosing to participate in Self-Governance arrangements. As of July 2016, the IHS and Tribes had negotiated 90 Self-Governance compacts with over 350 (or 60 percent) of the 567 federally recognized Tribes. This program represented approximately $1.8 billion (or nearly 40 percent) of the IHS budget (Indian Health Service, 2016c). A corresponding reduction in the size and presence of the IHS within those Tribal communities has also occurred as functions shift to Tribes.

2.8. Summary of Chapter

This chapter has provided a comprehensive overview of the context, history, and status of Native American Tribes in the United States, with a focus on Tribal Self-Governance (TSG) in health care. It began by defining Tribes and explaining the concept of federal and state recognition. The chapter then delved into the complex history of Indian policy and legislation, highlighting key

events that shaped the health care system for Native Americans. It introduced the concept of Tribal Self-Governance, tracing its evolution from the Indian Self-Determination and Education Assistance Act of 1975 through various amendments and demonstration projects.

The chapter has emphasised the importance of Tribal sovereignty and self-determination, explaining how these concepts had been interpreted and applied in the context of health care delivery. It described the transition from federal domination of health care services to a system where Tribes had increasing authority and flexibility to manage their own health care programs. The chapter also discussed the success of TSG programs, noting the significant increase in Tribal participation and funding over time, both with the Bureau of Indian Affairs and the Indian Health Service.

Finally, it touched on the complexities Tribes face when deciding whether to contract or compact for health care services, highlighting the balance between exercising sovereignty and navigating federal bureaucracy.

CHAPTER 3: METHODOLOGY

3.1. Overview

The development and validation of the Critical Success Factors (CSF) Framework has occurred in three distinct phases. Phase I involved the development of the initial framework and was completed prior to this research being instigated. This phase is comprehensively described in Chapter 4. The second (and main phase of this research, Phase II) focused on the verification and validation of the draft framework based on a mixed-methods design with multiple data sources: interviews, literature and new observations and the analysis of new documentation. Phase III focused on recasting the framework based on the validation, and with an eye to implementation including the possible implementation in an Aotearoa/New Zealand setting.

This chapter describes the research methods and research logic used for this research (Phases II and III). It begins with an explanation of Indigenous research theory, with a more in-depth analysis of the importance of utilizing Kaupapa Māori values within Indigenous research projects. It goes on to explain how the Kaupapa Māori research approach has been customized by embedding it within a Kaupapa Māori Standards framework developed by the Indigenous consultancy company that I own and work in. A reference to the ethics approval process is also included.

Phase I: This phase occurred prior to the current doctoral research. In Chapter 4, I give a full description of the development of the initial CSF framework. Development of the draft critical success factor framework emerged from three sources of evidence:

- observations of and participation in a large number of Tribal forums,
- a literature review (1999-2017), and
- a document review (grey literature and documents dated between 1999–2017).

Phase II: Validation of the draft critical success factor framework for Tribal Self-Governance through a further literature review (relevant literature or documents from 2018 onwards specific to the individual factors in the framework) and a member validation process conducted in 2019 and 2020.

Phase III: Analysis of findings from the validation process; updating of the critical success factor framework as appropriate to create my final version, and a quality assessment.

Lastly this chapter concludes with identifying limitations of the research approach and a chapter summary.

3.2. Indigenous Research Methodology

3.2.1. Indigenous research theory

Dr Matthew Makomenaw, Director of the Native American Cultural Center at Yale University, states that Indigenous research methodology is: *"one where the researcher understands the role of Indigenous history, culture, language, and self-determination in the lives of Indigenous Peoples."* (Makomenaw, 2012)

My entire career has been in the realm of Indigenous development, and my philosophy is rooted in understanding the history, culture and aspirations of Indigenous people for self-determination and Self-Governance. This thesis is an important milestone in my ongoing learning journey.

In their article on the use of Indigenous kaupapa Māori research methodology involving Indigenous women's realities, (Wilson et al., 2022) discuss the research interface to bring together Indigenous and Euro-Western ways of knowing. My research on Tribal Self-Governance in the U.S. required me to use an Indigenous research methodology that drew on traditional cultural knowledge with embedded critical and decolonisation theories to understand the circumstances of Tribes in the

U.S. Yet the results of my findings needed to not only satisfy and show respect for the knowledge and experience gained and shared by the Indigenous peoples of the U.S., but it needed to hold credibility with a western or 'mainstream' health audience if the findings were to have utility in Aotearoa New Zealand. Because of the shared histories of colonisation and modern realities shared by the Indigenous peoples of Aotearoa New Zealand and the United States, we both have an inherent connection to one another. Equally we both want research such as this to be culturally safe, relevant, respectful and meaningful to those researched to produce transformative knowledge.

Māori Researcher Professor Denise Wilson and her colleagues (Wilson et al., 2022) identify that research has been a colonisation tool that shaped the construction of Indigenous peoples post-settlement and how they were subsequently understood. See also (Archibald, 2019; Smith, 2012). They note that while positivist and post-positivist methodologies have dominated the social research landscape, the last two decades have seen the rise in Indigenous research approaches informed by Indigenous worldviews and ways of being. Linda Tuhiwai Smith's seminal work, Decolonising Methodologies (Smith, 1999), provided the impetus for globally evolving Indigenous research methodologies.

(Todd, 2016) states that a lot of 'scientific' research fails to contextualize historical and contemporary events that determine Indigenous realities and experiences. She further highlighted that a colonialist approach to research involves navigating a tension between Indigenous stories told without Indigenous peoples' involvement and not acknowledging Indigenous people at all (Todd, 2016).

Either way, authentic Indigenous voices are silenced, perpetuated by a lack of accountability. My research has sought to ensure not only that the Indigenous voices of U.S. Alaska Native and Native American Tribes are heard, but also that they have the opportunity to validate what I heard and transcribed into a framework. The validation process was an essential component of adhering to a Kaupapa Māori and Indigenous process.

I have intentionally avoided ‘individualised, deficit and victim-blaming’ research (Cram, 2013) by using a strengths-based approach that celebrates the achievement of U.S. Tribes while allowing the challenges to be relayed in an analytical and honest way. Chilisa notes that ‘Indigenous research methodologies aim to not only decolonize but also indigenise research (Chilisa, 2012). Such approaches enable research to be informed by an Indigenous paradigm and utilize those Indigenous and more local methodologies. Indigenous processes enable knowing the past and understanding contemporary realities.

Furthermore, Chilisa confirms that ‘the premise underpinning an Indigenous research paradigm is based on a shared way of viewing and thinking about the world that is reflective of Indigenous peoples’ unique worldviews, beliefs, values, and ways of living – it is holistic, collective, relational and spiritual in nature (Chilisa, 2012).’ (Smith, 2017) notes that ‘an Indigenous research paradigm is contingent on the relationships established and maintained between the researchers and the Indigenous community that ensure the research outcomes have relevance, meaning, and practical application for the community that can lead to transformation’.

(Sherwood, 2013) affirms that ‘research from an Indigenous standpoint must recognise the distinct cultural and linguistic traditions, unique historical experiences, and colonization’s enduring effects. Within and between nations globally, Indigenous peoples are culturally diverse despite sharing similar experiences and inequitable health and social outcomes compared to other groups of people living in their respective countries’.

Use of a Kaupapa Māori approach by Māori researchers has been validated as a legitimate and appropriate approach to take when dealing with Indigenous subject matter and participants. Māori researchers also describe methods that adopt the Māori worldview, beliefs, and principles and which fit better with Māori participants (Jahnke & Gillies, 2012; Jones et al., 2013; McCleland, 2011). This enhanced match between participant and method allows for a more collaborative research process. I have experienced strong alignment between our Te Ao Māori view of

collectiveness and collaboration to that of the Alaska Native and Native American Tribes of the U.S. over the years. Our shared commitment to the extended family and Tribe is a common feature of our social structures, along with our dedication to cultural and spiritual wellbeing. It is these shared worldviews that strongly supported and validated the use of an Indigenous approach within this research.

(Drawson et al., 2017) have developed a summary of Indigenous research methodologies and generally categorized these into the following five types:

1. General Indigenous frameworks
2. Western methods in an Indigenous context
3. Community-Based Participatory Research (CBPR)
4. Storytelling
5. Culture-specific methods.

All five types of Indigenous research methodology had the following components: Contextual reflection, in that the researchers must situate themselves and the Indigenous peoples with whom they are collaborating in the research process; inclusion of Indigenous peoples in the research process in a way that is respectful and reciprocal as well as decolonizing and preserving self-determination and prioritizing Indigenous ways of knowing.

All these factors came into play during my research as I situated myself within the North American Indigenous context and sought their participation through a collaborative and respectful engagement process. My key goal was not only to preserve self-determination but to learn from their experience to enhance our own self-determination aspirations as Māori.

3.2.2. Kaupapa Māori theory

At its core, this research has been carried out by an Indigenous researcher with the participants being other Indigenous peoples from North America. What has been important in this process, is to find the balance between being true to my own Māori values and beliefs, while respecting and humbling myself to the values and beliefs of my North American relatives – especially while I was a visitor within their traditional territories. Fundamental to my belief system is to know who I am in accordance with where I am. These beliefs are inherent within tikanga Māori (Mead, 2003) that aims to uphold the mana of both host and visitor, and are therefore a key element of a kaupapa Māori approach.

(Smith, 1997) stresses the need for kaupapa Māori principles to be in an active relationship with practice. He and many other prominent Māori researchers have provided the theoretical foundations for kaupapa Māori theory (Bishop, 2008; Pihama, 2001) and others validate the approach and set a pathway for inquiry and discovery.

In his thesis, (Bean, 2018) further affirms the importance of a kaupapa Māori theoretical foundation to his research as he sought to define Māori leadership within the public sector. As have I, he places importance on tikanga Māori and Māori values in his methodology. Other Māori academics also support the importance of tikanga Māori and Māori values as inherent to a kaupapa Māori approach (Mead, 2003). (L. Smith, 2005) clarifies kaupapa Māori as Māori and Tribal ways of knowing in the context of privileging Indigenous knowledge (mātauranga Māori), Māori customary practices (tikanga Māori), and cultural values (L. Smith, 2005). In my research I have aimed to privilege the Indigenous knowledge of my Alaska Native and Native American participants by recruiting more Tribal representatives than federal government representatives.

In his article on utilizing kaupapa Māori approaches to initiate research, (Rewi, 2014) examined kaupapa Māori approaches from four dimensions which included whanaungatanga as a

recruitment methodology and the significance of kanohi kitea (seen face) in the relationship with research participants. Whanaungatanga is defined as, "relationship, kinship, sense of family connection – a relationship through shared experiences and working together which provides people with a sense of belonging" (Rewi, 2014). The inherent connections between myself as an Indigenous wahine Māori from Aotearoa, and my Indigenous brothers and sisters from North America, is evident in our shared beliefs and principles – and are an expression of whanaungatanga. I have no doubt that our spiritual, cultural, and Indigenous common beliefs underpinned my participants' willingness to join in this research and to trust that I would honor their voices.

Whanaungatanga between us as Māori and our Native American relatives is further strengthened by our common desire for a nurturing relationship – one where we can truly see and hear each other. (Bishop, 1996) notes that from a research perspective *"becom[ing] a 'known face", a kanohi kitea…an essential step in establishing the trust that is a necessary feature of any research relationship*." (p.111). From a kaupapa Māori perspective the notion of trust is critical. Relationships can only be built on trust, and for this research I spent many years building trust through my constant personal presence among the Alaska Native and Native American Tribes, organizations, and leaders.

Kaupapa Māori and Indigenous methodologies also position the concepts of self-determination, the Treaty of Waitangi, decolonization, social justice, and transformation to the forefront of Māori methodologies (Smith, 2012). Graham Smith (Smith, 1997) highlights six intervention principles for kaupapa Māori transformation. They provide both a relevant and appropriate context for my research as they align well with the principles of TSG expressed frequently by our Alaska Native and Native American relatives. The principles are:

1. Tino rangatiratanga – the self-determination principle
2. Taonga tuku iho – the cultural aspirations principle
3. Ako – the culturally preferred pedagogy principle

4. Kia piki ake i ngā raruraru o te kāinga – the socio-economic mediation principle
5. Whānau – the extended family structure principle
6. Kaupapa – the collective philosophy principle.

The principle of tino rangatiratanga – the self-determination principle – is embedded in the Treaty of Waitangi and is considered in terms of mana motuhake (sovereignty and self-determination). (Smith, 2017) contends that tino rangatiratanga is about having meaningful control over one's own life and cultural wellbeing. All of these aspirations and concerns for Māori are just as valid and accurate for the Alaska Native and Native American Tribes. These shared aspirations for self-determination are the foundational premise for this research.

3.2.3. Kaupapa Māori Standards framework

The broad theory of kaupapa Māori (Smith, 1997) as well as my own Kaupapa Māori standards framework developed by and for my company (Kahui Tautoko Consulting Ltd, 2024), provide the basis for this qualitative research design and methodology. Kaupapa Māori theory positions Māori ways of knowing as the primary view.

A Kaupapa Māori approach underpins all work that I undertake whether as consultant or as a researcher. When working directly with Indigenous communities or organizations providing services for Indigenous people or working directly with Indigenous people from other Nations and countries, I aim to be true to myself and to be authentic. As a Māori, the standards I operate from are based on tikanga Māori (correct approaches and protocols) as that is how I was raised. In fact, I know no other way of being. A Kaupapa Māori framework also guides my relationships and engagement processes, ensuring the practices are both robust and culturally safe. My company Kāhui Tautoko Consulting Limited is an Indigenous consulting company focused on supporting the development of Indigenous peoples. My approach as a wahine Māori and a researcher is inextricably linked to my work as an Indigenous consultant. The Kaupapa Māori Standards

framework (Kahui Tautoko Consulting Ltd, 2024) was developed within Kāhui Tautoko Consulting Limited by staff and is shown below; these have also underpinned my approach to this research.

NGĀ TIKANGA WHAKAHAERE: KAUPAPA MĀORI STANDARDS
HE KĀHUI MAUNGA: Our common aspirations for self-determination as Indigenous peoples

WAIRUATANGA (spirituality): Acknowledgement of the moemoeā (Council) and matakitetanga (prophecy) by recognizing and respecting the belief systems of others. Wairuatanga is also an integral component of an individual along with taha tinana (physical), taha hinengaro (intellectual), and taha whanau (family) wellbeing (Durie, 1994). We integrate wairua into all practices, encouraging spiritual well-being and development and supporting the expression of wairuatanga in whatever form people feel appropriate and relevant.

MANA (authority, prestige): Building, valuing, promoting, and protecting our reputation as Māori that recognizes and respects the authority and reputation of whanau, hapū, iwi and Māori groups in Aotearoa, as well as that of other Indigenous nations. This standard includes continually striving to further develop and strengthen our reputation and valuing feedback.

TIKANGA MĀORI (correct custom, lore, process, protocol): Promoting Mātauranga Māori (Māori knowledge) with appropriate research, evaluation, and analytical processes and by extension being familiar with Indigenous protocols including being prepared for cultural engagements.

HE KĀHUI TANGATA Respecting each other's commonality as Indigenous peoples

WHAKAPAPA (genealogy, lineage): Understanding and celebrating the origins of Māori and other Indigenous people and the whakapapa of the individuals that we connect with. This also applies to understanding each organization that we work with and its place in the Indigenous community. At an individual level it also means acknowledging that every individual has an

extended whanau that is important to them and respecting that often those commitments to whānau come first.

KAIRANGI (excellence): Esteeming and maintaining high standards of professionalism and valuing high standards in the work undertaken. This includes practicing humility and being able to say, "I need help" or "I don't know the answer" and appreciating that the people you work with are experts in their own lives.

HE KĀHUI TAUTOKO: Supporting each other's aspirations as Indigenous people

MANAAKITANGA (care, homage): Valuing people through the acknowledgment of their mana (authority, prestige), respecting their points of view, perspectives, and behavior – especially in their own territory or home. It means supporting one another and showing hospitality to manuhiri (visitors) and ensuring that we manaaki manuhiri (host and care for visitors) at all times. Manaaki extends to the whānau (family/extended family) of people we connect with.

KAITIAKITANGA (stewardship, guardianship): Nurturing, consolidating, developing, and supporting Indigenous people to fulfil their vision, functions, and duties within their own communities. It includes strengthening organizations to work within their community, while respecting their views and beliefs, and empowerment by uplifting the mana of others to achieve their own self-defined aspirations.

TAUTOKO (support, advocate for): Empowering Māori and Indigenous peoples by focusing on positive outcomes for whānau, communities and Iwi for Māori development (and including other Indigenous Tribes, clans, and Nations. This includes practicing awhi (embrace, care) and respect for people, who they are and where they are from – and knowing one's place in that context.

3.2.4. Privileging indigenous voices through the narrative style

This thesis intentionally privileges the indigenous voices of the interviewees and other experts who contributed extensive knowledge to the research, and in particular the validation process. For this reason, some of their narrative – including verbatim quotes from references – may appear long, but it is designed to capture a more comprehensive version of their honest experiences in the way they have described it. This approach similarly is aimed at resonating with Māori audiences who I have come to learn over the years, are accustomed to oral storytelling and being taken on a journey through those stories. I privilege their voices rather than my own.

This Kaupapa Māori research narrative style is a culturally grounded approach that aligns with Māori worldviews, values, and practices, which are often underpinned by this story-telling style. Evidence shows that this narrative style is characterized by several key features:

Cultural Authenticity

Kaupapa Māori narrative style prioritizes authentic engagement with Māori cultural norms, values, and practices (Ruwhiu, 2008). It seeks to describe historical narratives and symbolic meanings which are rooted in Māori social processes, rituals, myths, and cosmology (Ruwhiu, 2008). This approach ensures that research is conducted in a manner that is culturally appropriate and respectful of Māori and indigenous ways of knowing and being.

Storytelling and Oral Tradition

The narrative style strongly emphasizes storytelling, reflecting a Māori cultural preference for narrative forms of communication (Wilson et al., 2021). It is a particular style that resonates with other indigenous people such as Native Americans, as they too have a history of oral tradition and passing of knowledge through storytelling. This approach resonates with the traditional Māori oral culture, where knowledge was passed down through generations via stories, genealogies, and

other forms of oral narrative (Wilson et al 2021). Pūrākau, a form of Māori narrative originating from oral tradition, is often used as a method in Kaupapa Māori research (Lee, 2009).

Holistic and Relational Approach

Kaupapa Māori narrative style takes a holistic view, avoiding the categorization of Māori reality (Wilson et al., 2021). It emphasizes the interconnectedness of all aspects of Māori life, including spiritual, physical, and social dimensions. The narrative often weaves together multiple strands of experience and knowledge, reflecting the concept of "raranga korero" or the weaving together of narratives (Wilson et al., 2021).

Indigenous Epistemology

This narrative style is grounded in Māori epistemology, challenging the dominance of Western research models (Mikahere-Hall, 2017). It affirms Māori cultural philosophies and practices, positioning Māori knowledge and experiences at the center of the research process (Mikahere-Hall, 2017). Positioning the voices of interviewees in this research was extremely important for me to honor their contributions and knowledge, and to better understand their realities that have emerged from their own colonization journey. As it is for Māori, the narrative often incorporates concepts, language, and metaphors to convey meaning authentically.

Participant-Centered and Co-Constructive

The narrative style emphasizes the active participation of research participants in constructing and interpreting narratives (Wilson et al., 2021). It allows participants to select, recollect, and reflect on stories within their own cultural context and language, rather than imposing the researcher's framework (Wilson et al., 2021). This co-constructive approach ensures that the resulting narrative truly represents the participants' experiences and perspectives. In order to achieve this, I asked interviewees to review my final draft to ensure I had constructed and interpreted their responses appropriately and reflected their context accurately.

Contextual Sensitivity

The narrative style is deeply rooted in the specific cultural, historical, and social contexts of Māori communities (Wilson et al., 2021) and for this research it was important to retain the U.S. focus on the Native American experience. The narrative style recognizes the importance of understanding narratives within their proper cultural and historical frameworks, rather than interpreting them through a Western lens.

Transformative and Empowering

Kaupapa Māori narrative style is not just descriptive but also aims to be transformative (Mikahere-Hall, 2017). It often addresses issues of social justice, self-determination, and the protection of Māori knowledge (Mikahere-Hall, 2017). The narrative may incorporate elements that empower Māori communities and contribute to positive social change. Certainly this thesis was written to influence transformative change in the area of self-determination and self-governance by Māori in Aotearoa, based on experiences of self-governance in the U.S.

By employing these elements, Kaupapa Māori research narrative style creates a culturally safe and relevant space for Māori knowledge to be shared, understood, and applied in research contexts. This approach ensures that research not only respects Māori cultural protocols but also contributes to the advancement and empowerment of Māori communities.

3.3. Ethics

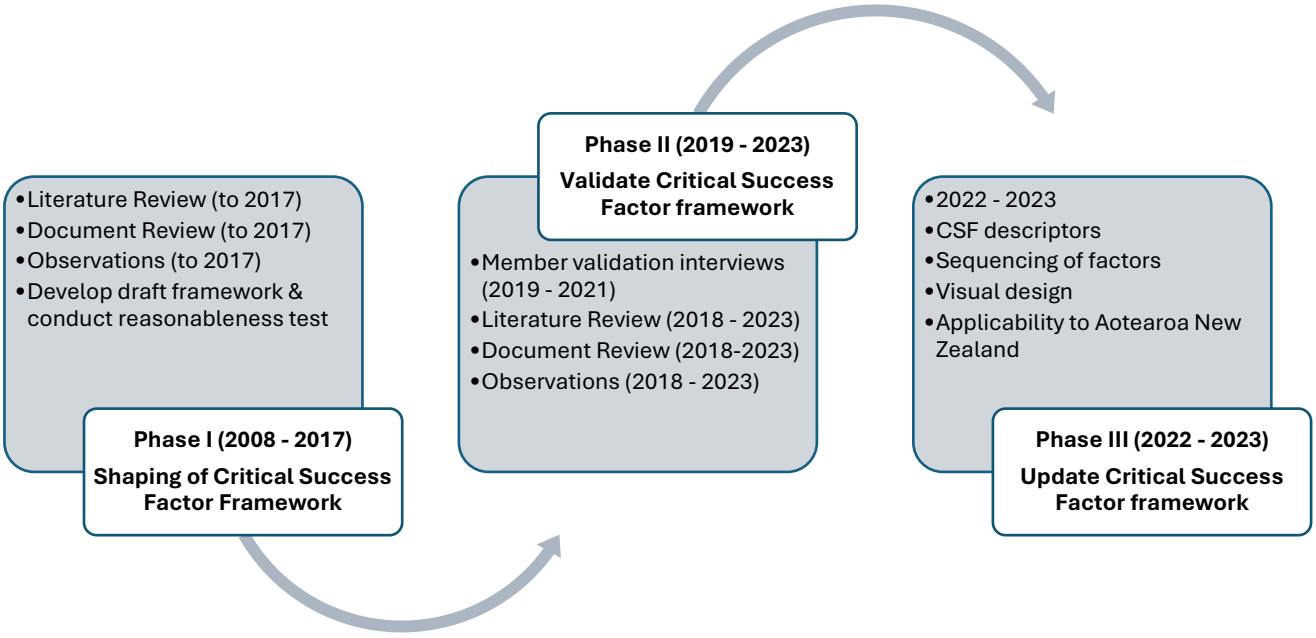
The Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2017), identified that as this research does not involve human participants from the perspective of collecting individual, identifiable, or personal information it meets the criteria for a low-risk ethical approval. The expectations were that participants would provide opinions and information based on their role, experience, and expertise

in the Indian health system as it relates to TSG. The thesis does not report on specific health outcomes for patients or members of self-governing Tribes. It focuses on the 'system' of Self-Governance, not the health outcomes arising from self-governing Tribes in health. The low-risk ethics application was approved on 4 December 2019 (See: APPENDIX B: Ethics Approval)

3.4. Research Method Overview

The research for this thesis has occurred in three phases described in the diagram below. Phase I is the prior research which is reported in Chapter 4. Phases II and III are described below and the results presented in Chapters 5 and 6 respectively.

Figure 4: Phases of the Research



3.5. Phase II: Validating the Critical Success Factor framework

The focus of this thesis is the validation of my proposed 'Critical Success Factor Framework for Tribal Self-Governance in Health Care' developed in July 2018. Informed by the Framework Analysis Method (Gale et al., 2013), I used three processes/data sources to conduct this validation: a (further) literature review on the proposed TSG success factors, continued observations during site

visits between 2019 – 2023, and an expert interview and member validation process with ten TSG practitioners – leaders and administrators.

3.5.1. Literature review on each of the TSG factors

For the Phase II literature review, my focus was targeted at finding any new literature related specifically to each of the nine critical success factors. I still used similar key words and added search words for each of the factors including:

1. Policy and politics
2. Tribal unity / collectives / collaboration(s)
3. State / Federal / collaboration(s)
4. Funding / resources / investment / financial
5. Data / information / research / Epi Center
6. Culture / cultural / identity / healers / traditional
7. Communications / education / promotion
8. Accountability
9. Workforce / training / scholarship(s) / health careers.

3.6. Phase III: Updating the Critical Success Factor framework

3.6.1. Triangulation Approach

To conduct the analysis phase, a triangulation approach was used. Triangulation is a term that is frequently mentioned in publications of qualitative studies, to show how the quality or validity of a study might be assured (Seale, 1999; Tracy, 2010). (Pelto, 2017) found that researchers began to use triangulation (defined as using more than one research method) as an approach to assessing the validity and reliability of data-gathering methods in the social and behavioral sciences. (Mathison, 1998) has since outlined an alternative way of conceptualizing

triangulation, suggesting that there are three possible outcomes of using the approaches to triangulation:

- **Convergence** – *"data from different sources, methods, investigators, and so on will produce evidence that will result in a single proposition about some social phenomenon"*
- **Inconsistency** – *"multiple sources, methods, and so on…. [generate] a range of perspectives or data that do not confirm a single proposition about a social phenomenon,"* and;
- **Contradiction** – the use of multiple methods results *"in opposing views of the social phenomenon studies*" (p. 15).

Drawing on the findings of the expert and member validation interviews, the added literature which expanded the evidence for each of the critical success factors, and my continued observations of Tribal Self-Governance forums, I was able to draw conclusions to adapt the original framework. The three sets of data from the interviews and the additional literature were easily coded into the 9-factor framework. From the original transcripts from the interviews, I was able to theme the comments/expert advice into my nine factors for each participant. This was because firstly when asked what they thought was important, their responses fell nicely into one of the factors and when asked for their feedback on my 9-factor framework, each was able to offer commentary of any factors they had not previously discussed. All of the key participants did have a comment to make about every factor, and they all thought each factor was relevant. This process further validated the overall framework.

What was evident from the feedback overall, however, was a need to rank the importance of each factor and place them in a particular order. While all of my nine critical success factors were

validated, the process revealed firstly that some are more critical than others and need to be addressed before you can move onto other factors and secondly that some factors take precedence above all others at different times, based on external environmental influences.

The analysis prioritized the major critical success factors and influenced the ordering of the factors. More significantly, when taken as a whole, the concept diagram to present the factors (the puzzle) also became redundant as validating members could not relate to the interconnectedness of the factors. It was unclear within the diagram whether there was an intended relationship between the puzzle pieces which touched each other (or did not) or whether the factors were presented in some sort of order or sequence. Furthermore, some participants highlighted the relative importance of some factors over others, so did not think equal puzzle pieces in the diagram reflected this.

Consequently, I spent time thinking about their feedback. I needed to re-think the use of a puzzle as a conceptual framework and my intuition was telling me to find an Indigenous framework that would better align with this Indigenous kaupapa (subject matter). In addition, I needed a conceptual framework that would reflect the necessary sequencing of the factors while also highlighting the importance of some factors over others. I then replaced the original diagram reflecting the factors with a new diagram that visibly looked more like an open-ended roadmap. This allows the reader to understand that like any journey, one can go backwards and forwards quite frequently before actually making progress. This allowed me to sequence the factors and to signify the ranking or relative importance of the factors. In some cases, two factors can or should be worked on simultaneously. Chapter Five provides more information about the refined framework.

3.7. Quality assessment

An assessment was undertaken to determine the quality of the validation process. The findings of the study will be reviewed by the participants who were involved in the Member Validation

process, and this will have a significant impact on assessing the quality of this study from those most familiar with it.

3.7.1. Internal Validity

Validation of the CSF framework, and subsequent changes, emerged from the member validation process and updated literature review. There were no other external factors or influences that led to the final framework apart from the conceptual representation of the framework. All member validations were transcribed and as much of their verbatim input included as possible. Members were also asked outright if the framework looked correct or was missing anything. The evidence showed that members supported the factors but strengthened it by adding layers of importance and the need to sequence the CSFs.

Responsiveness to the validation process was demonstrated because the original framework shifted during the course of the validation process due to member feedback and the updated literature review. Critical success factors were changed and ranking of importance and sequencing of the factors was introduced where it did not exist previously.

3.7.2. External Validity

This study can be generalized to other settings (ecological validity), other people (population validity) and over time (historical validity):

3.7.3. Ecological Validity

Ecological validity has applicability to different settings. It is transferrable to other settings including Aotearoa and potentially to other countries where Indigenous people are pursuing greater control and ability to self-determine, such as Canada for instance. The framework is adaptable and flexible based on how participants may need to respond to socio-political environmental factors. One or more factors may rise to importance at different times and may be important to different participants for different reasons, as illustrated in this validation process. As a consequence,

different factors can rise and fall in importance and prevalence at any time based on external environmental factors, or political opportunities.

3.7.4. Population validity

Appeal to different users: the framework can be used by both governments and Tribes for their own planning purposes. Additionally, the framework can be used by both small Tribes new to the world of Self-Governance, and larger more experienced Tribes, as each can assess where they currently stand in relation to each CSF and what they would need to do to embed all aspects of the framework into their Self-Governance plans. Applicability to different Indigenous populations: the aspirations for TSG in the U.S. and a greater in self-determination are not unique to U.S. Tribes. In fact, any Indigenous peoples who have been colonized by a foreign nation, and/or who are advocates for the United Nations Declaration on the Rights of Indigenous Peoples, and/or who are currently 'recipients' or 'providers' of services and programs, and not governors of the same – are potential populations who would find this study useful.

3.7.5. Historical validity

The CSFs and the framework are relevant today even though the TSG legislation and activity has been occurring since the mid-1990s. The historical reflections on TSG and how it has occurred, and the fact that self-governing Tribes have already 'implemented' many of the factors and sustained them through to today - for instance Tribal unity is sustained through the National and Regional institutions - demonstrates this form of validity.

3.8. Participant Sample

There is always a risk that a sample involved in such a study is not representative of the population of interest and that some sample selection bias may exist which prevents the study from accurately representing the population. All participants for this validation process have long histories of being involved in Self-Governance both on the Tribal side and the Federal Indian Health Service side. It is

the reason they were approached for the validation process as their views are more reliable and informed due to their experience. They can each provide strong historical knowledge as well as contemporary knowledge of what is occurring today, and how relevant these factors are today. All participants today are still integrally involved in Indian Health and TSG so there is a strong level of continuity of knowledge and experience among the group. Tribal participants were selected from all over the U.S. and not just one State or Tribe. Some work for individual Tribes and some work for or with multiple Tribes such as United Southern and Eastern Tribes (USET) or the Alaska Native Tribal Health Consortium (ANTHC). Representation of Tribal participants has come from Alaska to the Northwest, south and east of the U.S. as well as from national institutions.

If there is a gap in representation among the Tribal participants, it is that I did not approach Tribes from the Great Plains in the central corridor of America. I felt that my participant sample was sufficient to represent perspectives from across the U.S. since the Tribes based in this region of the country are strongly represented at the national level through the various national Tribal organizations who did participate. I have also included references to written and oral submissions of some of the leaders from the Tribes in this region where they have presented to Senate and Congressional Committees. Therefore, I have aimed to include their perspectives by different means through the document and literature reviews.

In addition to the validation participants, the literature review included statements and testimony from many other Tribal leaders, which supported the findings. As everyone who was approached agreed to participate there is no direct nonresponse bias.

For the above reasons, I believe the findings are valid and accurately represented in the updated CSF framework which emerged after the validation process.

3.9. Adaptation of the CSF framework following validation

The final adaptation of the CSF framework involved a three-step process based on the validation findings. My first task was to review the validation findings for each factor and then, where relevant, update the descriptor and summary content for the factor for instance, changing 'Infusion of Culture' to 'Tribal Identity and Culture.' My second task was to rank the importance of each factor by identifying which ones were more significant than others and depicting this through the size of the CSF factor in the concept diagram while also placing each factor in an appropriate sequence. My third and final task was then to re-design the overall framework visualization in a more Indigenous way where the whole connected system of factors was still visible, but the clarity of rank and order were more prominent. This was achieved through the use of a roadmap analogy which is presented in this thesis in Chapter 5: Updating the CSF Framework.

3.10. Limitations of the research

I consider there is one main limitation to this research and that is that there could have been more participants from Tribes from across the U.S. in particular from the Great Plains region. However, I am comforted by the fact that the study did in fact include the participation of Tribal members from Alaska in the west to the southern and eastern Tribes in the east. Additionally, there is evidence included in the study from Tribes located in the interior or Great Plains of the U.S. who have spoken many times at Senate hearings or released accessible media information. Additionally, I am also comfortable that the largest Tribe in the U.S., the Navajo Nation, while not formally included in the formal interview list, was visited by me during my many site visits and achievements of the Nation have been incorporated into this study.

Originally, I was also concerned that there was a dearth of literature on TSG and what the critical success factors for TSG are, but this limitation was overcome with the new evidence shared at the 30th anniversary Senate hearing for TSG held in 2018 (U.S. Senate, 2019). As an insider researcher,

practitioner, and Māori, I faced a risk of jumping to conclusions or at least trying to find material or responses that supported my original theory described within my CSF framework. There is a potential for bias that has the potential to reduce the validity of this work (Kayrooz & Trevitt, 2004). The quality assessment undertaken after the validation process was the method that I used to prevent this bias from occurring. Additionally, by asking members for their thoughts first, before sharing my hypothetical framework, I sought not to influence their thinking.

3.11. Chapter summary

This chapter has described the Indigenous research foundation for this study from a kaupapa Māori perspective, which is further supported by the application of my own Kaupapa Māori Standards framework used within, and developed by, the Indigenous company that I own and work for. As the research is by an Indigenous Māori researcher of an issue of great importance to another Indigenous group, it has been vital for me to ensure each stage and process is underpinned by kaupapa and tikanga Māori, as inherent within this approach is respect for self and other people through upholding important values such as mana and kaitiakitanga.

I have outlined three clear phases of the research: the first was to provide supporting evidence for my hypothesis that there are nine critical success factors that support TSG; the second phase was to validate my theory through gathering further evidence and member validation; and the third phase was to solidify and strengthen the original theoretical model to reflect the findings of the validation process. One of the most important research tasks was the member validation process which engaged Tribal and Government leaders and advocates to gather their perspectives on what factors are critical to their success in TSG and whether there is a sequence, relative importance and inter-connection or inter-dependence between these factors. The engagement of the members relied on well-developed prior relationships which are the hallmark of whanaungatanga – the principle of connection and common interest. Without their contribution, it would have been nigh on impossible

to confirm whether my hypothesis was valid. A quality assessment was undertaken to ensure the findings were valid before finalizing the framework that has resulted from this work.

Having described the research design and methodology, the next chapter discusses Phase I: The development and design of the critical success factor framework which is the hypothesis being tested within this research. The validation process then follows in the next chapter followed by the adaptation of the framework post-validation.

CHAPTER 4: INTRODUCING A CRITICAL SUCCESS FACTOR (CSF) FRAMEWORK

4.1. Overview

This chapter focuses on Phase I of the broad project that was undertaken prior to this research. It covers the development and description of my initial critical success factor framework for effective TSG. Each of the nine critical success factors is described in detail with supporting evidence from the research and provides the rationale for my identification of these factors as being critical to the model of TSG. The development of presentation of the initial framework is provided in detail as it is not available elsewhere.

4.2. The Genesis for my Interest in Identifying the Success Factors

From 1999-2018 I visited many of the Tribes in their communities and on their Tribal Reservations. I also attended the annual Tribal Self-Governance Conferences, where Tribal leaders gathered every year to share their experiences, discuss current issues and to continue their strategizing for the future. The Federal partners from the Bureau of Indian Affairs and the Indian Health Service were also in attendance at these annual conferences and they too presented on the work they were doing.

During this period I gathered many materials from the conferences such as the printed conference agendas which identified keynote speakers and breakout sessions; copies of current policy papers on health and other issues which were generally made available by the national Tribal organizations; handouts and PowerPoint presentations from breakout sessions; marketing materials such as fliers and brochures from Tribes and private entities who had exhibition booths at the conferences; and research posters.

From the Tribal visits I collected annual reports, organizational handouts, Tribal news articles or newspapers, Tribal newsletters, patient handouts, and information brochures. I also

observed a great deal. I watched and listened to Tribal and Federal leaders discuss current issues in their keynote presentations, breakout session presentations, plenary sessions and during individual site visits. I took copious notes of these presentations and discussions, and these pages of notes were also added to my collection of Tribal and Federal materials. Over the years I amassed a wealth of material that I would often refer to during my consulting work in the Indigenous health field.

Developing key relationships with both Tribal and Federal government leaders and representatives over the past 20 years has been an essential component of developing this framework. Many of these relationships are well developed and I am pleased to regard many of the Tribal and Federal leaders as personal and professional friends. Our bond is reflective of the whanaungatanga described as an underlying value for this research process in the previous chapter. I have able to conduct my observations, gather information and to ask questions of these colleagues because my colleagues know my interests are genuine and come from a pro-Indigenous self-determination position. These relationships have also helped me to complete the member validation interviews and to have honest and authentic conversations. Without their willingness to share information with me and to provide their insights, I would not have been able to develop the CSF framework.

Figure 5: Mara Andrews with Ben Smith, Deputy Director, IHS November 2018 at Board meeting of the United Southern and Easter Tribes in Nashville. With permission of Ben Smith

4.2.1. Consistent Themes Begin to Emerge

Each time I would leave a conference or a Tribal site visit, I would reflect on what I had learned and finish reading material and resources I had collected from that specific trip. I would develop key themes of what I learned from that visit and over time these thoughts began to crystallize into a consistent set of themes. The more I spent time with my Native American and Alaska Native relatives – the more these themes repeated themselves.

These themes became the basis of my framework for the critical areas of concern for Tribes governing their own health care and were validated after each visit. They were issues that were repeated over and over again at the conferences and at the Tribal site visits – typically they would talk about policy and legislation, or persistent workforce and funding challenges, or data and technology needs, and the relationship (good or otherwise) with their Federal partners at State, Federal, White House, Senate and Congressional level. I found that I could organize both my materials and my draft notes into these themes.

4.3. Prior Research: What are the factors that make Tribal Self-Governance successful?

4.3.1. Literature review on Tribal Self-Governance

The literature review focused on gathering evidence and relevant literature that relates to defining Self-Governance and TSG, and anything specific that related to the critical success factors (CSFs). Using the literature review described in Figure 8 below, I used key search words in different combinations:

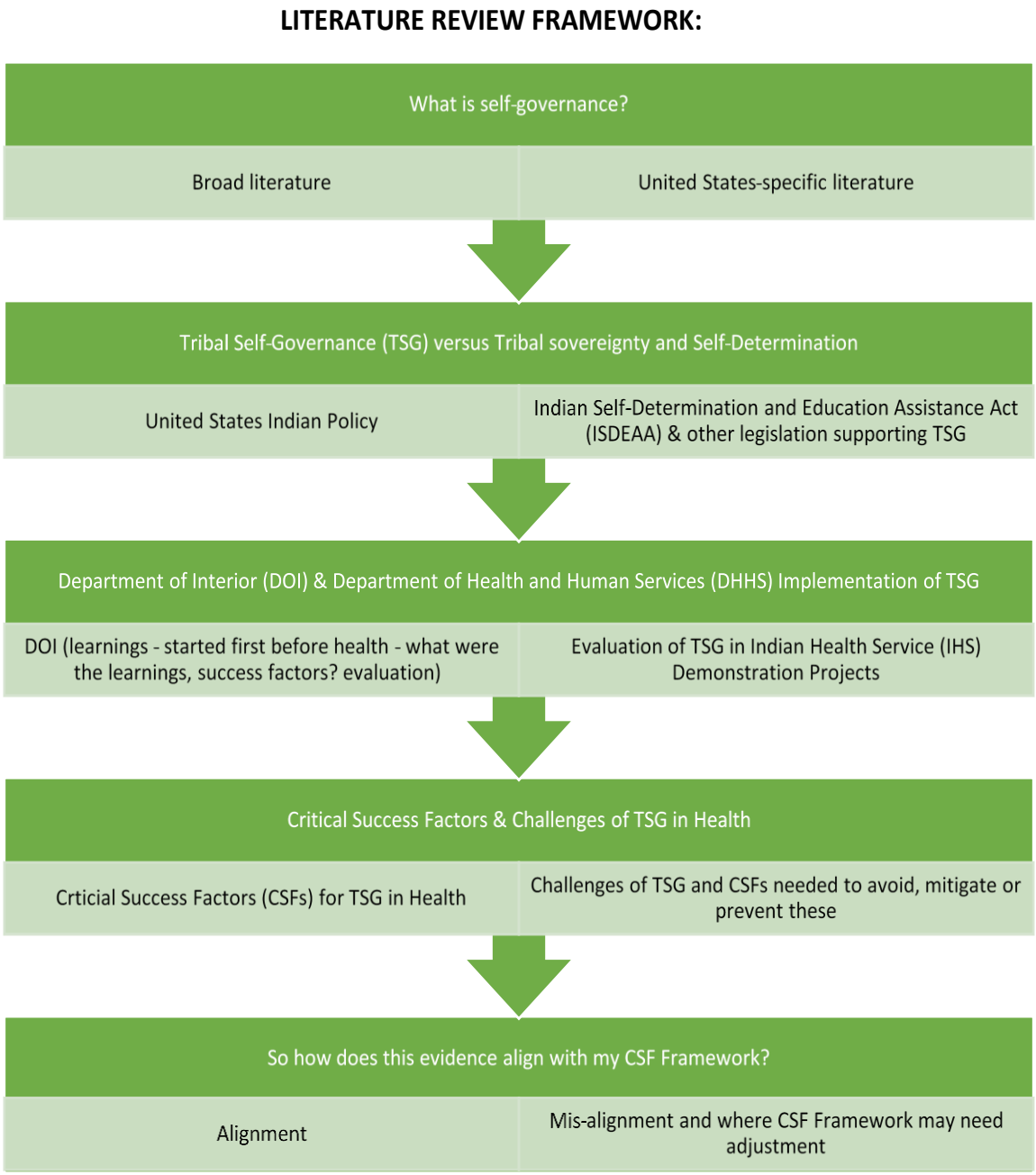
- Indian, American Indian, Native American, Alaska Native
- Native, Indigenous, Tribe, Reservation, USA / America
- Indian Health / Tribal Health / Urban Indian health
- Self-Governance / governance / Tribal Self-Governance
- Success / critical success / evaluation.

Search strings are given in APPENDIX E:

I reviewed broad literature on Self-Governance and U.S. specific literature on TSG. I also reviewed academic reports, studies, and journals on Indigenous Self-Governance. Using sources such as CWIS (Center for World Indigenous Studies), Harvard, academic institutions, online academic libraries in the U.S. and other Indigenous research groups, yielded further research on TSG.

I then reviewed literature related to the implementation of TSG in the U.S. Some of the reports used in the document review to create my CSF framework were also referenced, including particular references to success factors, or barriers that need to be overcome through successful mitigation strategies. My approach to this task was designed broadly to identify, obtain, and assess published and unpublished research of TSG and management of health and social services programs, focusing on Department of Health and Human Services: Indian Health Service programs.

Figure 6: Literature Review Framework



My preliminary literature review produced a limited number of published studies about the system associated with Tribal Self-Governance of federal programs. Consequently, the literature search and review methods included supplementary activities such as search of internet websites to identify background papers, issue papers, data sources, projects, and studies relevant to my study topic, and a search of websites of federal government agencies that have responsibilities for health, to identify relevant data sources, studies, and initiatives for this research. The first step in the

literature search was of published literature through standard sources, including MedlinePlus, American Indian/Alaska Native (AI/AN) Health, Native Health Research Databases and Research Gate.

As a secondary step, I also searched some of the references cited in each publication to identify additional relevant literature. Once the published literature bibliography was compiled, I expanded the search through identifying and reviewing websites of national Indian organizations that are concerned with health issues. These organizations included National Congress of American Indians (NCAI); National Indian Health Board (NIHB) and Area Indian Health Boards (AIHBs); Self-Governance Communications and Education Tribal Consortium (SGCETC); National Indian Education Association (NIEA) and Native Nations Institute (NNI). In addition, I searched relevant federal government websites including Indian Health Service / Department of Health and Human Services; Administration for Native Americans; Bureau of Indian Affairs / Department of Interior; Center for World Indigenous Studies; Senate Committee on Indian Affairs (SCIA) and the White House Council on Native American Affairs.

Fortunately, during the period of my research, the Tribal Self-Governance policy celebrated its 30th anniversary in 2018 and included a Senate Committee on Indian Affairs hearing in April 2018. There were many written and oral submissions presented by Tribal leaders and politicians from across the U.S. which provided additional documents for review.

The opening statement by the Hon. John Hoeven, U.S. Senator from North Dakota is particularly poignant and foundational to my research. Senator Hoeven reflected that:

> *"Today's hearing commemorates the 30th anniversary of the enactment of one of the most successful laws in Indian history, the Indian Self-Determination and Education Assistance Act Amendments of 1988. This Act, passed by Congress in 1988, was the result of critical*

input and leadership from Tribes across our country, and marked a significant turning point in Tribal Self-Governance" (United States Senate, 2018, p.1).

4.3.2. Document Review

As mentioned in my Personal Statement, after relocating to Canada I became embedded in First Nations health care, but was also able, due to proximity, to reconnect with U.S. colleagues and strengthen my networks there. This led to many visits over the years to conferences, Tribal reservations, and Indian Health Service facilities across the country. This has been further supplemented with some of the projects that I have worked on for clients in New Zealand, Canada, and Hawaii including organizing study tours for Tumu Whakarae (the National Forum of Māori General Managers from New Zealand's District Health Boards) since 2014 to Canada, the U.S., and Hawaiian sites. and visiting Alaska with the First Nations Health Council several times to look at governance models and subsequently writing reports on the lessons learned.

I visited self-governing sites in the U.S. such as the Northwest Tribal Indian Health Board (Portland); Seattle Indian Health Board (Seattle); Seminole Nation (Florida); Navajo Nation (Window Rock, Arizona) and the Gila River Health Corporation (Phoenix). I established a relationship with staff visiting the Tribal Self-Governance Unit at the Indian Health Service Headquarters in Washington DC and some regional sites (e.g., Phoenix Indian Medical Center (Arizona) and Gallup Indian Medical Center (New Mexico). I met more people visiting the National Indian Health Board (NIHB) and National Congress of American Indians (NCAI) in Washington DC. I wrote reports on models of governance for various clients.

During this time, I gathered many materials including speeches from keynote speakers and breakout session presenters; policy papers; informational and marketing materials; annual reports; Tribal media articles and research reports during my visits.

I would consciously read the materials I had gathered writing down questions, themes, and key points. I would make a point of finding the speaker or presenter the next day to explore any subject further if I needed more detail. I wanted to be sure my interpretations and understanding were correct before I returned home. Over time, I gathered, read, and absorbed boxes of material, and often used the knowledge in my consulting work. If there was any structure to my information collection, it was limited to collating packets of documents by conference or site. I had literally collected boxes of material over the 1999-2017 period.

In preparation for this research, I sorted all of the documents into nine piles of relevant information for each of the nine factors. Apart from the documents sourced during the literature review phase, I did not, at this stage in the process, look for any more documents to support each of my nine factors. The supporting evidence for the nine factors in my CSF framework is based solely on my observational experiences and the documents I had on hand as of 2017. My documents were varied:

- Copies of relevant legislation (Indian Self-Determination and Education Assistance Act or ISDEAA and its amendments and other relevant copies of legislation);
- Self-Governance Communication and Education Tribal Consortium (SGCETC), Indian Health Service (IHS) and other TSG materials, resources and newsletters, handouts, leaflets;
- Conference packages, policy papers and presentations from conferences and workshops;
- Annual reports, promotional materials, newsletters, and reports produced by Self-Governing Tribes managing their own health facilities and programs;
- Research and evaluation reports from academic institutions, consultants, Federal agencies, Tribes and working groups;

- Sample submissions, speeches and testimonies made by Self-Governing Tribal leaders, the Indian Health Service and Bureau of Indian Affairs that related to successes and challenges with Self-Governance;
- Examples of Compact Agreements and policies used to promulgate Self-Governance arrangements.

I then systematically reviewed the collated information and identified key facts and findings which I felt made each factor relevant to the overall framework. I also drew on reports I had written in my consultant role on site visits we had undertaken or on specific topics requested by clients and drew out key facts providing further rationale for specific factors. I attached the relevant information to each of the factors to develop the nine descriptors in Chapter 3. When I reviewed the documents, I noted that no new themes emerged that would support more factors for the CSF framework.

4.3.3. Observations and Learnings

The observation technique is used mostly in qualitative research. It involves overt and/or covert observation of individual or group behavior in a specific situation (Mack, 2005). Observation is particularly useful since use of survey methods alone would not be sufficient to reflect the full nature of what has transpired in the TSG system. A second key element of observation is to capture the unexpected, unusual, or unsaid. Observation in person is useful to get a better understanding of context, and to cross-check information and possible differences between what people do and what they say they do. It is possible to assess the quality of relationships between individuals or groups e.g., relations within the household, and between different parts of a community for example in relation to patronage, dependency, or ethnicity (Adler & Adler, 1994; McKechnie, 2008; Spradley, 1980). As a research method observation helps to gain new insights or to discover things that people may not wish to reveal in interviews or may not be asked about in surveys and may not have thought of mentioning, and to build rapport with informants.

Figure 7: Tribal Self-Governance Conference: Typical Panel of Tribal Leaders Hosting Conference

Note. Image source: Photo by Mara Andrews

I observed a great deal over the 1999-2017 period. I watched and listened to Tribal and Federal leaders discuss current issues in their keynote presentations, breakout session presentations, panel sessions and during individual site visits. I took notes of these presentations and discussions, and these pages of notes were also added to my collection of Tribal and Federal materials. I watched the interactions between Tribal and Indigenous health leaders, and between them and Federal Government officials. I spoke to many of them to explore issues further and to find out the nuances of the information that are often unsaid in public presentations.

I also documented themes from my informal observations gained from:

- Attending 11 Tribal Self-Governance, National Congress of American Indian and National Indian Health Board conferences.
- Completing 29 site visits to Native American health organizations (national, regional, and local) during the period 1999-2017.

- Visiting 10 Universities to review their Native American programs and initiatives, and;
- Visiting 9 area and headquarter offices of the Indian Health Service (see APPENDIX D: Observation Report and Key Learnings).

I attended the 2010 Tribal Self-Governance Annual Conference and the 2017 NIHS 8th National Tribal Public Health Summit and drew on these two primary sources of information to write descriptions for each of the nine factors to support my reasoning for selecting them as the core components of the framework. Each factor's description contains comments from observational evidence as well as documented evidence.

As well as being an observer and participant in 11 Tribal conferences held between 1999-2017, I have also been an observer at Compact negotiations (Alaska); Tribal Advisory Group meetings with the Indian Health Service; Indian Health Service Director 'Listening Sessions' with Tribal leaders, and various Tribal Board meetings. Through this I have learned the 'norms' of protocol and communication between Tribes, and between Tribes and the Federal government, as well as the pressing issues that concern Tribal leaders. Not only have I been able to observe the proceedings, but having become a regular conference attendee, I have developed a number of relationships with key leaders involved in Tribal Self-Governance both at the Tribal level and the Federal Government level. I maintained contact with many of them by email in between conferences, especially to organize site visits, and I enrolled on several email mail lists from key organizations to keep up to date with events occurring in the TSG environment.

I have purposefully attended specific workshops in areas where I felt I needed to build my understanding. APPENDIX D: Observation Report and Key Learnings, contains a list of all of my site visits and a high-level description of the observational themes from each site visit. These are

used and described in more detail in Chapter 3 to support the descriptions of the critical success factors. My confidence that the observations made and documented as themes are accurate is based on being accompanied by other New Zealanders and we would jointly write up the reports and learnings of the visits. Additionally, my constant returning to the U.S. meant I had many opportunities to validate and fact-check things with friends and colleagues in the Indian Health system. My intention was to develop a sound description of the relevant information (behavior) through observation according to best practice (Adler & Adler, 1994) and to align those observations with my CSF framework, or identify additional CSFs.

The literature review and document analysis led to the creation of my CSF Framework. The framework evolved over the years as I analyzed information and created themes from what I was learning and hearing. The thematic analysis was used in my consulting work, especially when I had to write advice papers for Indigenous clients. Over time, the nine CSF themes that I came up with were a constant for me. They helped me to respond quickly when someone asked if I had any information on a specific topic. These were the most important topics that mattered to the Tribal leaders in the U.S. and to advancing their Self-Governance agenda.

I merged the key findings from both literature review and observation and applied them to each factor. The full description of the original 'untested' CSF framework is in Chapter 3: Developing the Critical Success Factor Framework. I decided to develop a simple diagram which I felt would reflect the inter-connectedness of these nine factors (see Figure 8: Nine Critical Success Factor Framework and Key Characteristics). For me, each was connected to the other like a puzzle, and if one puzzle piece was missing, then the overall model would not work. I subsequently learnt during the validation process that this diagram fell short of what I was trying to convey.

4.4. Consolidating the Critical Success Factors

Practice-led research (Candy, 2006) such as that reflected in this thesis, is concerned with the nature of practice and leads to new knowledge that has operational significance for that practice. In a doctoral thesis, the results of practice-led research may be fully described in text form without the inclusion of a creative work. The primary focus of the research is to advance knowledge about practice, or to advance knowledge within practice. Such research includes practice as an integral part of its method and often falls within the general area of action research. I organized my materials which were examples of the practice of TSG, into nine themes which were:

1. Policy and Political Will
2. Successful partnering
3. Accountability
4. Unified Tribal leadership
5. Qualified workforce
6. Sustained communications and inclusion
7. Infusion of Indigenous culture
8. Flexible funding and revenue sources
9. Robust data and measurement.

Developing the critical success factor (CSF) framework focused on defining each of its nine components. The evidence used in this phase of the work informed the design and content of the CSF framework and enabled me to defend my reasoning for including each particular factor. I reviewed all of the documents I had collected (in paper form and e-form) during the 1999-2017 period and identified key information that supported each of the nine factors.

In 2018, I developed a simple picture of the nine themes that emerged from my analysis to utilize for my PhD confirmation proposal. I felt the nine factors were like puzzle pieces – they all

needed to fit together to make the whole, and none was more important than the other overall, even though at times one factor might have prominence at a particular time. The nine factors were in no particular order or ranking. All I knew at this point, was that if we (in Aotearoa New Zealand) were to learn from our friends in the United States and look at how increased governance in health care could work, we would need to have a plan for addressing and implementing all nine of these factors. I deliberately chose a weave pattern to highlight the interconnectedness of the factors *viz* Figure 9 below:

Figure 8: Nine Critical Success Factor Framework and Key Characteristics

4.4.1. Description of Each Factor (in no particular order):

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Policy and Political Will	Tribes individually and collectively need to demonstrate strong political will to advocate for changes that empower Tribes to self-govern - while reducing dependence on Federal / Government program delivery in their communities. Tribes need to work politically and legally with Governments (State and Federal) to create the legislative and policy environment needed for Tribal Self-Governance (TSG). This includes promoting TSG among State representatives who are elected to Congress and influencing policies of the sitting Government (including sitting Presidents / Vice-Presidents) and leaders across both political parties. Aiming for bi-partisan policy helps to ensure continuity. Tribal leaders (individually and collectively) need to advocate and educate politicians about the benefits of TSG for Tribes and for other citizens. Tribes need mechanisms to maintain a watching brief on emerging policy and law changes to ensure new policies and laws do not undermine or interfere with TSG, but enhance it	Tribal advocacy and leadership resulting in recognition of Indian rights to self-govern (Nixon, 1970) Tribal work with Congress & Senate members that led to passing of TSG legislation (1975) for Bureau of Indian Affairs programs, and expansion to include Indian Health Service programs (1988) Expansion of scope of TSG legislation by Patient Protection and Affordable Care Act aka Obamacare (2010) due to advocacy by Tribes with President Submissions to Senate Committee on Indian Affairs by National Congress of American Indians (NCAI) and National Indian Health Board (NIHB) by Tribal leaders Policy and research technical capacity employed by National Congress of American Indians (NCAI) and National Indian Health Board (NIHB) maintains watching brief on policy and law changes – and informs Tribes (including preparing briefings and submissions) Governors, Senate and Congress representatives are continually invited to annual Tribal Self-Governance Conferences and National Indian Health Board conferences to keep them informed

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Successful partnering	Tribes need to partner with one another locally, regionally and nationally to advance TSG, to learn from one another, and for larger Tribes with greater capacity to protect the interests of smaller Tribes. Tribes need to partner with State and Federal Governments, private sector entities and academic institutions to support and accelerate TSG. These partners can offer expertise, resources, knowledge, research and sometimes add capacity to Tribal capability. Tribes can seek opportunities for investment from partners of resources (human, financial, physical) towards successful win-win outcomes. Tribes need to partner with Law Firms that understand Indian policy, history and aspirations. They need to understand Constitutional, Fiduciary, Trust and Treaty rights to be effective partners to Tribes. The necessity to protect TSG interests for Tribes is dependent on sound legal advice and representation.	State and Regional Health collectives (e.g. Alaska Native Tribal Health Consortium (ANTHC); United South and Eastern Tribes (USET) collective of 33 Tribes; Indian Area Health Boards such as Northwest Portland Area Indian Health Board) Best Practice conferences to share learnings (e.g. annual Tribal Self-Governance conferences; USET Tribal Best Practices Conference; National Congress of American Indian – exhibitors and presenters on best or latest practices) University of North Dakota Medical and Nursing programs for Native Americans; Harvard University on research about economics of TSG Partnership of Department of Defense with ANTHC for Alaska telehealth system Hobbs, Straus, Dean and Walker LLP and Sonosky, Chambers, Sachse, Endreson & Perry, LLP are frequent sponsors and presenters at TSG conferences and are two high profile law firms among several firms that specialize in Indian policy and legislation

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Accountability for all	Tribal leadership (e.g. Councils, Presidents, Governors) need to ensure accountability / reporting to citizens on progress with TSG and financial management. Tribal leadership needs to be regular, consistent and honest. The risk of not doing so may cause citizens to lose support for TSG and/or to retract support for Tribal leadership. If accountability at Tribal level is not strong, a mistrust of leadership by citizens can spread to neighboring Tribes through word of mouth. Self-governing Tribes need to ensure accountability of the national and regional Tribal entities to which they belong. The risk of loss of Tribal members to regional and national entities can undermine their strength and representation, and lose the confidence of Government and private partners. Self-governing Tribes need to maintain accountability to Government for any reporting requirements that they may hold under Agreements / Compacts. Failure to be accountable for expectations under agreements impacts reputation and recognition of Tribes for further TSG opportunities by Government. Conversely, Tribes must ensure Government accountability to Tribes (Reciprocal Accountability approach) to hold them to account for agreements, commitments, Constitutional and Treaty rights. This may be done informally or legally through Court action.	Annual State of the Nation addresses (by individual Tribes such as Navajo and by the National Congress of American Indians) Tribal communications (websites, social media, annual reports, newspaper media, speaking engagements in communities, conferences) Tribal appointment processes to Regional and National entities\, and democratic voting for President(s) of National entities by Tribal leaders. Appointment of Tribal Health Care Entity Boards and CEOs / Leaders by Tribal Councils (e.g. Gila River Indian Community selects Board for Gila River Health Care Corporation; Cherokee Nation Tribal Council appointment to Cherokee Health Board) to ensure accountability link between health entity and Tribal Council Government Performance and Results Act (GPRA) reporting by Tribes to Government based on agreement Government performance measures Reporting by Tribes to Office of Management and Budget (OMB) including submissions to OMB Class action by multiple Tribes against Indian Health Service for Contract Support Costs (https://www.dorsey.com/newsresources/publications/client-alerts/2024/6/tribes-win-healthcare-contract-support-costs)

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Unified Tribal leadership	Tribes need to unify the commitment to enter into TSG among their own citizens to gain their support for removing Government delivery of programs and replacing it with Tribally-led delivery (per Tribe). Tribes opt into TSG once they have citizen majority support to do so. Tribes who come together regionally can achieve economies of scale for the work they have to do to maintain TSG such as preparing submissions, briefings, workforce development activity and policy making. Larger, wealthier Tribes can support the interests of smaller Tribes. The idea that collective efforts "lifts all boats" not just those with capacity, reigns when working together. Regional entities can gather individual views, synthesize these views and present a position on matters to national entities. Regional entities can appoint representatives to national entities to ensure the linkage to information and accountability. Tribes need to unify collectively at a Regional and Tribal level in order to influence policy & legislation that supports TSG (see Policy & Political Will above). Without united voice, the Federal Government becomes reluctant to change policy or law due to lack of nationwide support by Tribes. This is especially so to expand TSG opportunities to other Departments where TSG is initially limited to one or two Government Department programs.	370+ Tribes now in TSG arrangements[2] out of total 574 Tribes; New Tribes are opting in each year[3] Some Tribes have opted out of TSG as their citizens have not supported TSG and wish to retain Indian Health Service program delivery – this is a self-determination decision Self-governing Tribes' creation of the Self-Governance Communication and Education Tribal Consortium (SGCETC) to support TSG Tribes (e.g. organizing communications, resources and conferences) and promoting TSG among Tribes who have not opted in yet State and Regional Health collectives (e.g. Alaska Native Tribal Health Consortium (ANTHC); United South and Eastern Tribes (USET) collective of 33 Tribes; Indian Area Health Boards such as Northwest Portland Area Indian Health Board) National Council for Urban Indian Health (NCUIH) to represent the interests of urban entities National Indian Health Board (1972) and National Congress of American Indian (1944) enable Tribes to work together on national / federal issues National Advisory Groups to BIA and IHS allow Tribes to bring their local and regional voice to national advisory group tables convened with BIA and IHS leadership to influence Departmental policy and activity

[2] https://www.tribalselfgov.org/resources/participating-tribes/

[3] https://www.tribalselfgov.org/slug/5-office-of-self-governance-presentation/

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Qualified workforce	Tribes need to ensure they educate, inform and enable Tribal leaders to become expert and competent advocates, and to be strong Tribal leaders. This can include continual briefings on legal matters; advice from Tribal policy technicians; briefings to Tribal leaders from Government, regional and national entities. Tribal leaders should attend formal training opportunities. Similarly, Tribes need to grow and attract competent Health Care Leaders who can quickly gain the confidence of leaders and citizens once Tribes take over from Government program delivery. Tribes have the option to have Government employees work for the Tribe once the devolution of programs comes into effect, providing continuity of care and human capability. The Government also continues to develop its own workforce to maintain service delivery to non-TSG Tribes, complemented by academic programs in health offered by Universities. Tribes with workforce challenges can develop their own programs ("Grow your own") that grow the Indigenous workforce. This reduces reliance on recruitment of non-Tribal citizens. Tribes with financial resources can attract trained / expert Tribal members to 'come home' to work for the Tribe, through incentives such as Scholarships.	Example: Native Nations Institute at University of Arizona: Indigenous Governance, Law and Policy program Attorney briefings to leaders and submissions prepared for Senate Committee on Indian Affairs[4] Policy and Research teams at NCAI and NIHB give policy advice to leaders regionally and nationally Alaska Native Tribal Health Consortium – Community Health Aide Program; Dental Health Aide and Behavioral Health Aide programs originally developed for Alaska and more recently spread to other parts of the U.S. Navajo Nation: Office of Navajo Nation Scholarship and Financial Assistance to 'educate, enable, empower' Navajo citizens by paying for study; paying for transfer back to the Tribe; repaying student debt; providing scholarships. Department of Health and Human Services (DHHS): Technology Transfer Centers (TTCs) to provide training and resources for workforces in areas such as Mental Health and Addictions. Indian Health Service offers scholarships, workforce training programs, IHS Loan Repayment program, and preferential hiring policies. University of North Dakota: Indians in Medicine (INMED) and Recruitment and Retention of American Indians into Nursing (RAIN) programs.

[4] USET statement to Senate Committee 8 March 2023 on Native Communities Priorities - https://www.congress.gov/event/118th-congress/senate-event/333737/text

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Sustained communication and inclusion	Tribes need to create communication capability to share TSG information (including achievements, benefits and challenges) with all stakeholders (Government, TSG Tribes, non-TSG Tribes, partners, academic studies). This keeps TSG on the public 'radar' and aims to ensure continuation and growth / expansion of TSG of Government programs, while also winning the hearts and minds of non-Tribal citizens. Tribes individually, regionally and nationally need to ensure communication occurs in all forms (social media, online, paper, conferences) for all audiences to make it highly accessible. Individual Tribes need to ensure communications are targeted at their citizens and all the way up to Tribal leaders, State leaders, Federal leaders and Politicians through their regional and national channels.	Tribal mail and email lists held by NCAI, NIHB, SGCETC and regional entities to spread and receive information Tribal submissions to Senate Committee on Indian Affairs and Office of Management and Budget Appearances at Senate, Congressional and Legislative hearings and placing statements on record in advocating for TSG in health with associated policy, law and funding SGCETC maintains a calendar of events for all conferences as well as announcements from agencies SGCETC convenes annual TSG Conference NCAI convenes two national Congress conferences per year and smaller meetings in between on specific subjects NIHB convenes annual Tribal Health Conference and Best Practices forums Indian Health Service issues various communications: Dear Tribal Letters; Blogs; Notifications and Alerts and Director convenes Listening Sessions. IHS has a Tribal Consultation Policy for all matters requiring engagement with TSG Tribes Government issues Legislative updates ("Washington Report")

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Infusion of Indigenous culture	To even consider TSG, Tribes need to confirm the Tribal mandate. A key element is providing assurance that TSG will strengthen and sustain their unique Tribal belief systems, identity, native language & customs, traditional healing & medicines and cultural aspirations. This includes embedding cultural thinking into service delivery models. Tribes' unique structures need to be protected in any TSG arrangement and acknowledged where they differ from other Tribes (e.g. clan system, village system, chapters). In some cases, Tribes visually display their identity through physical means – building design, artwork, jewelry, sovereign flags, community icons, carvings, signage, displays and clothing. This is both encouraged and celebrated. Tribal citizens can be concerned that aligning with other Tribes may impact their own identity and standing. It is important that unique Tribal cultural characteristics are elevated in the TSG process, especially when Tribes partner with other Tribes. Culturally-centred dispute resolution mechanisms are also encouraged to help address disagreements among Tribes. It is essential that such a protocol is agreed early (while things are 'good') so that the protocol can come into effect when there is potential conflict. The risk is that without such a protocol, Tribes may walk away from the table and matters are left unresolved (and worse, the unity is impacted negatively).	Tuba City Regional Health Care Corporation (part of Navajo Nation) has an Office of Culture and Language as part of its health system to promote use of the language and Navajo customs in health care Some Tribes maintain native language interpreters on staff (e.g. Navajo, Cherokee) South-Central Foundation created the NUKA model and aligned their values and operations with this model Some Tribes have established Sweat Lodges and other traditional healing programs as part of their health care delivery system (e.g. Navajo, South-Central Foundation) Many Tribes have sovereign flags that are displayed in their communities and at conferences Health center building designs are very often reflective of the local culture and icons (rivers, mountains) and contain a lot of local artworks (e.g. Gila River Health Corporation; Cherokee Health; Choctaw Health Care Alaska Native Health Board and Alaska Native Tribal Health Consortium: Dispute Resolution protocol – members agree to Tribal Caucus to discuss issues behind closed doors, and never in front of Government

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Flexible funding and Revenue sources	Tribes need to advocate for maximum transfer of funds from the Government in the TSG transfer or devolution process (i.e. the Compact Agreement). Whatever the Government is spending at Headquarter, regional and local level – for the Tribe, needs to be transferred to the Tribe. Negotiations and calculations are therefore critical to the process to ensure the Tribe receives maximum and fair funding. The use of the Compact Agreement ensures the Tribe has full flexibility to make its own decisions about the use of the funds once they receive them. Even after transfer of programs and funding, Tribes need to continually advocate for Government to address inequities in funding. Tribes also need to continue to advocate for access all forms of revenue equal to other health operators, over and above what is transferred in the TSG arrangement. Tribes need to make decisions on whether they will invest their own funds to top-up the Government funding in order to provide additional services or health facilities for their citizens (perhaps in lieu of paying dividends). Tribes who do self-invest would do so while continuing to advocate for Government funding to address inequities.	Tribal advocacy for Government to uphold Federal Trust and Treaty responsibilities (ongoing) The National Tribal Budget Formulation Workgroup was established to determine equity gap in funding transferred from IHS to Tribes. Their budget report is regularly updated i.e. For YE2022 the gap was $48bn Tribal access to IHS Grants (e.g. workforce, research) Access to Medicaid Funding (after passing of Obamacare 2010) Access to Contract Support Costs over and above Health Program Delivery costs Development of Joint Venture Construction funding to help Tribes build health facilities Access to Veterans Affairs funding for patients who are Veterans (over and above IHS funding)

CRITICAL SUCCESS FACTOR FOR TRIBAL SELF-GOVERNANCE	DEFINING CRITICAL ACTIONS IN THE TRIBAL SELF-GOVERNANCE PROCESS	EXAMPLES OF DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
Robust data and measurement	At the outset of TSG, Tribes should determine the expected outcomes and indicators for TSG so that achievements, changes, and challenges can be reported to show the benefit of TSG. The Tribe needs to ask itself 'what does the Tribe want to achieve culturally, socially, financially? What health status indicators will demonstrate success?' Ideally the Tribes regionally and nationally agree to a set of national health status indicators that they can all commit to. This strengthens the ability to report on positive impacts of TSG on the state of Native American / Alaska Native health since taking over from the Federal Government – and it helps to communicate success to Tribal citizens. Tribes need to acquire or build Health Information Technology and expertise to support data collection and reporting. They also need to acquire technology for delivery of health care virtually. Tribes need to identify research priorities and draw on partners to support research that supports an evidence-based approach.	Health Information Technology (HIT) National project in place to re-design HIT across IHS and the Tribes Tribal Data Capacity study completed Tribal Data Exchange provides a common dataset for TSG Tribes Regional Tribal Epidemiology Centers in place across USA to gather data from Tribes for analysis and reporting, and to conduct research Baseline Measures Workgroup developed a set of 6 outcome outcomes and 150 indicators in 1994 Native American Research Centers for Health (NRCH) in place to support Tribally led academic research Tele-health technology is in place in a number of TSG communities (e.g. Alaska Federal Health care Access Network)

In the following sections I describe this initial Critical Success Factors in more detail, consolidating the observations, literature and document analysis which informed its development.

4.5. CSF 1: Policy and Political Will

This factor has a dual focus. On the one hand it is critical for Tribes themselves to have the political will and Tribal mandate from their citizens to enter a TSG arrangement, since it is optional.

On the other hand, it is important to have the appropriate policy platform and political will of Government politicians to facilitate the pathways for TSG by Tribes to support their aspirations.

4.5.1. Political Will of Tribes for TSG

Engaging with Tribal citizens is a key pre-requisite role for Tribal leaders before entering into TSG negotiations (G. D. Strommer & S. D. Osborne, 2014). Determining whether to enter or not to enter TSG arrangements is an important sovereign decision. Tribal citizens need to support their leaders to enter TSG arrangements. There are situations where citizens determine that they want to stay with the status quo because the IHS may employ many Tribal citizens; they are satisfied with the current services; or they do not believe the Tribal leadership has the capacity or capability to assume control from the IHS. Tribal leadership may determine that they do not want to be exposed to the risks, or they may simply have other priorities. The IHS Office of Tribal Self-Governance (OTSG) has personnel dedicated to helping Tribes prepare for TSG through education, information sharing and capability support. The Department of Transportation has produced a handbook to support TSG negotiations (U.S. Department of Transportation, nd).

According to the Self-Governance Communications and Education Tribal Consortium (Tribal Self-Governance, 2017), over 350 (approx. 62%) of the 567 Tribes are self-governing, meaning approximately 38% of Tribes or over 200 have elected to remain as direct service Tribes accessing their health care services from the IHS. The TSG program constituted approximately $1.8 billion (~40%) of the IHS budget (Indian Health Service, 2016c).

4.5.2. Policy and Political Will of the Federal Government for TSG

The government's adoption of TSG policy (Nixon, 1970) and enactment of associated legislation through the Indian Self-Determination and Education Assistance Act 1975 (ISDEAA) are what have created the necessary policy environment of the Federal government. Favorable Indian policy and the legislation permits transfer of government programs to Tribes if and when

they so choose. However, even then, the Federal government still must implement the law and commit appropriate resources to bring the law to life.

Up until the Obama Administration (President Obama January 2009 – January 2017), the ISDEAA had been in place since 1975, but under a regime requiring regular re-authorization by the prevailing government. The Tribes had to repeatedly lobby for the legislation to be renewed whenever it was due to expire, and they fought constantly for permanent authorization over the decades and with the advocacy support of their local, regional, and national entities. It was during the term of President Obama that the Tribes finally had the legislation permanently authorized within the scope of the Patient Protection and Affordable Care Act enacted on 23 March 2010 and commonly known as Obamacare. This was a significant achievement for all Tribes across the country.

4.5.3. The Importance of Education and Advocacy by Tribes to Generate Political Will

Tribal leaders rely on the advocacy of Federal politicians at all levels to pass, authorize or amend laws to benefit Tribes. Tribal leaders spend considerable time at a State-level, building relationships with and educating their State Governors, Senators, and local Congressional representatives to help them to understand Tribal circumstances, aspirations and their Constitutional, Treaty and legal rights as sovereign Nations. Tribes advocate very hard for bipartisan support for TSG, and their power in U.S. elections has been a focus (Wyman, 2022).

The need for political allies is especially important because (a) there are very few Native Americans in the U.S. Congress on whom Tribes can rely for political influence and (b) Native Americans and Alaska Natives lack voter power as they number 679 million or 2.09% of the total U.S. population (US Census Bureau, 2012, 2023). Tribal leaders focus on advocacy for the U.S. Government to meets its Trust and Fiduciary responsibilities to Tribes expressed through Treaties, law, and the Constitution.

4.5.4. The Desire and Barriers to Expand TSG to other Agencies and Departments

Many self-governing Tribes are continuing to advocate for extension of the TSG policy to more Federal agencies beyond the Bureau of Indian Affairs (BIA) to other bureaus and agencies; beyond the Indian Health Service (IHS) to other agencies within DHHS, and beyond the recently added Department of Transportation (U.S. Department of Transportation). The refusal and/or delay in expanding the TSG program to other branches of the BIA and DHHS, and delays in expanding the policy of the TSG program beyond BIA and DHHS to other Federal Departments, has been a huge source of frustration for many Tribes (Self-Governance Communication & Education Tribal Consortium, nd; U.S. Government Accountability Office, 2018).

4.5.5. Summary

CSF 1: Policy and Political Will emphasises the importance of political will from both Tribal entities and the federal government in implementing successful TSG arrangements. For Tribes, internal support from citizens is crucial before entering TSG negotiations.

On the federal side, the adoption of TSG policy and legislation, particularly the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975, created the necessary environment. A significant milestone was reached during the Obama administration when the ISDEAA was permanently authorized within the Affordable Care Act, eliminating the need for regular reauthorization.

Tribal leaders engage in extensive advocacy and education efforts to generate political will, building relationships with state and federal representatives. Tribes continue to advocate for the expansion of TSG to other federal agencies beyond the Bureau of Indian Affairs and Indian Health Service.

4.6. CSF 2: Successful Partnering

Partnering already occurs at many levels with Tribes and are constructed to accelerate and advance Tribal priorities by bringing partners together who have influence, resources, and expertise. Partnerships include those between individual Tribes or collectively when they come together regionally. This mechanism often allows for larger Tribes to support smaller ones (First Nations Development Institute, 2022).

There are also partnerships between Tribes and various Federal agencies for different projects, as well as with the local State Governments where Tribes are located (Self-Governance Communication & Education Tribal Consortium, nd). There were many partnerships between Tribes and academic institutions as well as between Tribes, non-profit and philanthropic organizations who operate in the Tribal coverage area and who provide additional benefits for Tribal citizens. Finally, there are partnerships between Tribes and the private sector including suppliers such as health technology businesses or law firms (GeBBS Healthcare Solutions, nd; Health Tech Academy & Native American Jump Start, 2024; Native Health Group, nd).

4.6.1. Tribal collaborations

There are many Tribal collective structures across the U.S. nationally, regionally and locally which support coordination and unity while also offering opportunities for achieving economies of scale by sharing capacity, professional / technical services, and technology. The national institutions which bring Tribes together are discussed in the section on Tribal Unity. There are several regional partnerships which exist across the U.S. primarily because the large geography of the U.S. necessitates it (e.g. United South and Eastern Tribes or USET with 33 Tribes as members (United South and Eastern Tribes, nd)), but also because there are natural groupings of Tribes which often date back many centuries. What is notable is that each of these national and regional entities have operated for several decades and have been able to sustain their inter-Tribal relationships.

4.6.2. Tribal collaborations with the IHS

The partnership between self-governing Tribes with the IHS is particularly interesting. Since Tribes draw their Self-Governance resources from the IHS, the only way that they can negotiate for more IHS funds, is to help the IHS to gain increased funding appropriations from Congress. Once new appropriations are provided to the IHS's core budget, self-governing Tribes are entitled to their share of those resources under their Compact Agreements.

Tribal leaders make submissions for higher appropriations to the IHS at Federal budget hearings. Both Tribal and IHS leadership acknowledge that the IHS is severely underfunded, and that unless the IHS is in a position to receive more equitable funding, the Tribes (both self-governing and direct service) will not benefit. The fact that the IHS' full detailed budget is shared so transparently and routinely with Tribes, and that Tribes 'went to bat' for the agency budget along with the agency itself, was a new phenomenon for me (Indian Health Service, 2016a, 2016c).

Tribes and the IHS also partner with other agencies such as the Veterans Administration to bring about health benefit for their Veteran citizens (Indian Health Service, 2021a).

4.6.3. Important Legal Partners

Law firms are also important partners to Tribes and a handful of law firms in the U.S. dedicate their entire portfolio to what is called "Indian country" work (Holland & Knight, nd; Jenner & Block LLP, nd). Historically, "Indian country" was considered the areas, regions, territories, or countries beyond the frontier of settlement that were inhabited primarily by Native Americans. Colonists made treaties with Native Americans agreeing to offer services and protection indefinitely in exchange for peaceful transfer of Native American land. Today this legal classification ("Indian country defined," 2024) defines American Indian Tribal and individual land holdings as part of a reservation, an allotment, or a public domain allotment.

Having sound reliable and knowledgeable attorneys, who are well appraised on Indian policy and legislation, is critical to advance the needs of the Tribes. Attorneys also play a key role in educating Tribal leaders on laws (emerging and current) that affect Tribes so that Tribal leaders become more informed and capable advocates for their Tribes. The Attorneys keep a watching brief on impending or unexpected policy and law changes; they prepare briefs and submissions to protect Tribal interests; and they often represent Tribes at various hearings.

Law firms also help their Tribal clients to keep the government accountable, even to the extent of filing lawsuits on behalf of Tribal clients against specific agencies for perceived illegal behavior by government officials. These particular partnerships are critical in the Self-Governance environment as there are constant challenges and opportunities which arise that would be difficult for Tribes to keep track of, without the right expertise on hand to do this specialized task for them.

4.6.4. Academic Partnerships

Many Tribes have academic partnerships such as the Harvard Project on American Indian Economic Development (HPAIED) (Cornell & Kalt, 1987) to support educational initiatives, knowledge sharing and workforce development, including educating Tribal citizens to achieve higher qualifications. Academic institutions also undertake research for and with Tribes; they produce resources; they run learning workshops; and they offer specialist support through their knowledge capacity (Makomenaw, 2012). Such institutions also, like many Tribes, are often large employers and they influence the economies of local towns and cities. Their presence is often very strong. I noted a number of academic institutions frequently attending TSG conferences either as exhibitors, speakers, presenters, and/or conference sponsors.

4.6.5. Summary

CSF 2: Successful Partnering recognizes the crucial role that diverse partnerships play in advancing Tribal priorities and improving health care outcomes.

Tribes engage in multiple levels of partnerships, including Inter-Tribal collaborations, Federal partnerships, particularly with the Indian Health Service (IHS), Legal partnerships with Specialized law firms and Academic partnerships with institutions like the Harvard Project on American Indian Economic Development to support education, research, and workforce development. These partnerships are essential for leveraging resources, expertise, and influence to accelerate Tribal health care initiatives. They allow smaller Tribes to benefit from the support of larger ones, provide opportunities for shared services, and help Tribes navigate complex legal and policy landscapes.

While challenges exist, such as potential power imbalances or conflicting interests, the overall impact of these partnerships has been significant in advancing Tribal Self-Governance in health care.

Tribes cannot undertake the TSG journey alone. The evidence has shown that Tribes select loyal and reliable partners, who are willing to work in a mutually beneficial and respectful way to advance their strategic agenda.

4.7. CSF 3: Accountability for All

At all levels, between Tribal leadership and citizens; between Tribes and the Federal Government; and within Government, there is a strong need for accountability, and there need to be mechanisms that enable and facilitate these various accountabilities to be met.

4.7.1. Tribal accountability

The primary accountability for Tribal leaders is to their citizens, both those who live on the reservation and those who live elsewhere. Tribal leaders also maintain accountability to their citizens through a variety of means such as the usual methods of disseminating Annual Reports and audited accounts, convening Annual General Meetings (AGMs), and convening community forums to report out. Many also report their activity through other means including newspapers and

newsletters; social media, internet, and website updates; Town Hall meetings; Advisory Boards; Patient Review Committees and Patient surveys; Quality improvement processes and Election processes. Tribes see accountability reporting not only as a responsibility to their citizens, but also as a means of recording their achievements, and sustaining citizen support for their ongoing governance role, including future elections.

4.7.2. Accountability to the Federal Government

Tribes are also required to be accountable for the funds they receive from the government and other funders, with data and narrative reports which are often required in standardized reporting templates. The ISDEAA has been amended many times, primarily by making it easier for Tribes to contract and allowing greater levels of self-determination. While Compact agreements are a large step forward for Tribes, Tribes still have to provide specific services in specific ways and engage in a large number of administrative tasks related to the contract. Tribes that have self-governing contracts draw down the money quarterly and do quarterly reports. Yearly audits are required if a Tribe receives more than $750,000 a year.

> *"Title 2, Code of Federal Regulations, Chapter II, Part 200 (2 CFR 200) requires non-Federal entities expending $750,000 or more in Federal funds during a fiscal year (FY) to have a Single Audit conducted for that year. However, for FYs beginning prior to December 26, 2014 the threshold is $500,000." (U.S. Department of the Interior, p.5).*

Many Tribes still raise concerns however at the administrative burden of reporting (U.S. Department of the Treasury, 2023).

4.7.3. National institutions

The national Tribal entities such as the National Indian Health Board and the National Congress of American Indians (NCAI) must maintain accountability to Tribes who mandate them to act on their behalf. Primarily this is facilitated through the Tribal leaders who are elected by Tribes

in each region and who then govern the national entities as Board members. National entities also disseminate information on their achievements and performance, and report their activity through National conferences and conventions, AGMs, and various forms of media. The President of the NCAI for instance delivers a "State of the Indian Nation" address each year for Tribal leaders (and also to influence the government on specific issues), delivered in the same week as the U.S. President delivers a State of the Union address (National Congress of American Indians, nd-b).

4.7.4. Indian Health Service

The IHS is accountable to the general public through the typical government reporting mechanisms such as Congressional and Senate hearings and reports, and publishing achievements against expected Government standards including such indicators as those contained in the Government Performance and Results Act 1993 (GPRA) which was later amended in 2010 ("Government Performance and Results Act Modernization Act," 2010). The requirements under this Act are discussed under the Robust Data and Measurement section later in this chapter.

The U.S. Government Accountability Office (GAO) is an independent, nonpartisan agency that works for Congress. Often called the "congressional watchdog," the GAO examines how taxpayer dollars are spent and provides Congress and federal agencies with objective, reliable information to help the government save money and work more efficiently (U.S. Government Accountability Office, nd).

4.7.5. Summary

CSF 3: Accountability for All highlights that for Tribes who are self-governing, there are multiple stakeholders to whom they must account.

Tribal leaders maintain accountability to their citizens, and sustain their support, through various means, including annual reports, community forums, and modern communication channels like social media. Accountability to the Federal Government is primarily financial, with Tribes

required to report on funds received and services provided. While Self-Governance compacts have increased Tribal autonomy, significant administrative tasks remain, including quarterly reports and annual audits for Tribes receiving over $750,000 in Federal funds.

National Tribal entities, such as the National Indian Health Board and the National Congress of American Indians, are accountable to the Tribes they represent. This is achieved through elected regional representatives and regular reporting at national conferences and conventions.

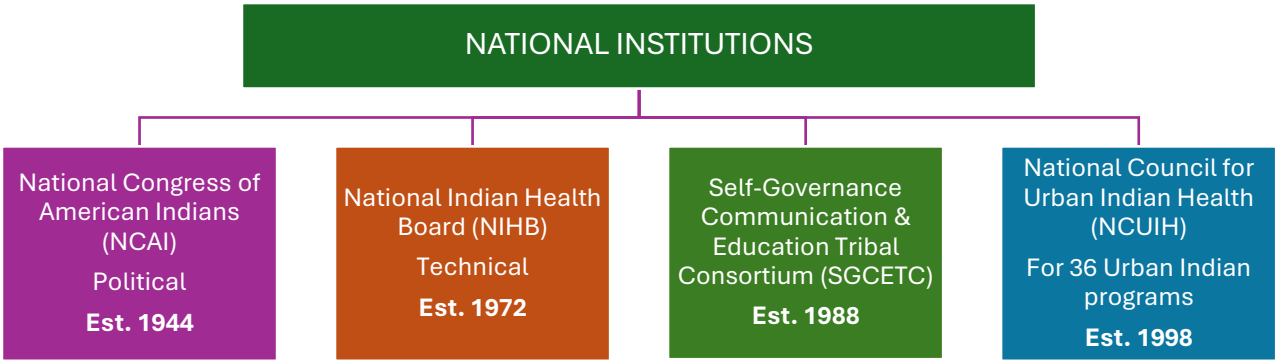
This comprehensive accountability framework aims to ensure responsible governance and effective use of resources in Tribal health care. However, balancing the requirements of various stakeholders while maintaining Tribal self-determination remains an ongoing challenge.

4.8. CSF 4: Unified Tribal Leadership

Working together locally, regionally, and nationally to bring about and implement change, is achieved when Tribal leaders are able to speak with one voice. One method for Tribes to achieve this level of clarity of purpose is through the joint development by Tribal leaders of their Strategic Plan such as that produced for the 2019-2021 period (Self-Governance Communication and Education Tribal Consortium, 2018a). Such a plan informs Tribal leaders on what to advocate for locally and regionally while also informing national entities on the priorities of Tribes. The plan also provides a useful tool for the Federal government to know what the priorities are for self-governing Tribes.

Figure 9 below which I developed, describes the national entities which enable Tribes to have a voice at the national level through their elected representatives on the Boards of these entities.

Figure 9: Diagram of National Representative Bodies for American Indian and Alaska Natives



4.8.1. National Congress of American Indians (NCAI)

The NCAI is the "backbone for the Tribes to maintain their Government-to-Government relationship with the U.S" (National Congress of American Indians, 2020). One example of the work of the NCAI that I reviewed was a White House Briefing Book for Tribal Leaders who were attending a national Tribal meeting convened by the then President in 2015 (The President, 2015).

The paper presented all key issues supported by the Tribes across the U.S., which were validated at an annual Tribal meeting. These types of tools empower, inform, and prepare Tribal leaders, and build credibility and consistency among leaders.

The NCAI's political expertise is also critical for Tribes. The Federal government is a State-centric government as appointees come from States who elect members to Congress, either to the House of Representatives or to the Senate. It is very important therefore that the NCAI give advice, information, and education to State governments, to prepare State appointees to meet their Trust obligations to Tribes when in Federal government and to uphold the Federal-Tribal relationship because of their fiduciary responsibilities.

4.8.2. National Indian Health Board (NIHB)

The National Indian Health Board (NIHB) is a non-profit organization established in 1972 that represents Tribal governments in advocating for improved health care for American Indians and Alaska Natives. Located in Washington DC, NIHB works with both Tribes that operate their own health care systems and those receiving care directly from the Indian Health Service. The organization provides various services, including policy analysis, research, program development, and legislative advocacy to address health disparities and promote culturally appropriate health care for Indigenous communities. The NIHB supports the NCAI's policy work through provision of health data and evidence (National Indian Health Board, nd-a).

4.8.3. National Council of Urban Indian Health (NCUIH)

The National Council of Urban Indian Health (NCUIH) is a national non-profit organization dedicated to supporting and developing quality, accessible, and culturally competent health services for American Indians and Alaska Natives living in urban areas. Established over 25 years ago, NCUIH serves as a resource center and advocate for urban Indian health, providing technical assistance, training, policy support, and other services to Urban Indian Organizations (UIOs) across the United States. The organization aims to improve health outcomes for urban AI/AN populations through advocacy, education, and culturally appropriate health care initiatives (National Council of Urban Indian Health, nd).

More than 70% of American Indian and Alaska Natives (AI/AN) now live in urban areas in the U.S., as compared with 45% in 1970 and 8% in 1940 (Norris et al., 2012). Urban Indians receive health care from a variety of sources, but the most important source of health care is through the Indian Health Service who fund 13 Urban Indian Health Programs (UIHPs) in different parts of the U.S. The UIHPs affiliate to the National Council of Urban Indian Health (NCUIH) whose mission is to support its membership.

4.8.4. Self-Governance, Communication and Education Tribal Consortium (SGCETC)

The Self-Governance Communication and Education Tribal Consortium (SGCETC) was established in 1988 and is a non-profit consortium of Tribal nations that elected to use Self-Governance for the delivery of programs and services for their citizens and communities. They ensure that the tenets and purpose of Self-Governance are accurately communicated and clearly understood by Congress, the Administration, Tribal nations, and all other interested parties (Self-Governance Communication and Education Tribal Consortium, nd-a).

4.8.5. National Advisory Groups

As well as the national legal entities, there are also National Advisory Groups hosted by the Indian Health Service which aim to ensure Tribal perspectives are sought for work undertaken by the agency for and with Tribes. Three key advisory groups have been operating at the Department of Health and Human Services for some time and include several Tribal leaders: Tribal Self-Governance Advisory Committee (TSGAC); Direct Service Tribes Advisory Committee (DSTAC) and DHHS Secretary's Tribal Advisory Committee (STAC).

The TSGAC provides information, education, advocacy, and policy guidance for the implementation of Self-Governance within the Indian Health Service (IHS). It serves as a liaison for Self-Governance Tribes on policy, legislative, budget, and program discussions. Established in 1996, TSGAC consists of Tribal leaders representing nations that administer health care programs through Self-Governance compacts with the IHS. It was further strengthened by the Tribal Self-Governance Amendments of 2000 (Self-Governance Communication and Education Tribal Consortium, nd-b).

DSTAC was established in 2005 and is comprised of elected/appointed Tribal Leaders from nine IHS Areas with Direct Service Tribes. It offers advocacy and policy guidance by regularly providing recommendations to the IHS (Northwest Portland Area Indian Health Board, nd).

The primary purpose of STAC is to seek consensus, exchange views, share information, and provide advice and/or recommendations to the Department of Health and Human Services (DHHS). STAC facilitates interactions between Tribal leaders and DHHS leadership. It serves as an important forum for Tribal input on DHHS policies and programs (U.S. Department of Health and Human Services, nd).

4.8.6. Summary

CSF 4: Unified Tribal Leadership emphasizes the importance of Tribal leaders working together at local, regional, and national levels to implement change and advocate for their communities' needs. Several key national organizations that facilitate this unified leadership: ***National Congress of American Indians (NCAI)*** serves as the primary interface between Tribes and the U.S. government, providing political expertise and advocacy. ***National Indian Health Board (NIHB)*** focuses on improving health care for Tribes through policy analysis, research, and legislative advocacy. ***National Council of Urban Indian Health (NCUIH)*** supports health services for urban American Indians and Alaska Natives, addressing the needs of the 70% of the population living in urban areas. ***Self-Governance Communication and Education Tribal Consortium (SGCETC)*** promotes and supports Self-Governance initiatives among Tribal nations. With the NCAI almost reaching its 80th anniversary, and the NIHB about to celebrate its 50th anniversary, these organizations have amassed a wealth of experience, evidence, and historical knowledge that will undoubtedly continue to support the ongoing efforts of the Tribes.

In addition, there are a number of national advisory groups such as the ***Tribal Self-Governance Advisory Committee (TSGAC)***, ***Direct Service Tribes Advisory Committee (DSTAC)***, and the ***DHHS Secretary's Tribal Advisory Committee (STAC)***, which provide platforms for Tribal input on policies and programs. These organizations collectively enable Tribes to speak with a clearer voice, inform national priorities, and maintain government-to-government relationships with the United States. By working together through these entities, Tribal leaders can more effectively

advocate for their communities' health needs and implement positive changes in health care delivery and policy. There is also a very clear separation between Tribal Governments who are governing their own health systems; those Tribes receiving health care services from the IHS and the Urban Indian Health programs.

Without these mechanisms to bring the voices of Tribes together to provide consistent messaging to external parties, the successes achieved by Tribes to date would not have been possible.

4.9. CSF 5: Qualified Workforce

For TSG to be effective, the leadership and front-line workforce needs to be well-qualified and informed.

4.9.1. Building capacity of Tribal leaders

One area that was particularly impressive was the development of knowledge and competencies of Tribal leaders. Not only are Tribal leaders in health care often highly knowledgeable about their community's needs from growing up in their own communities, but they are also exposed to a range of supports once they attain leadership positions in health care. Tribal Attorneys for instance spend time educating leaders on the legislation that impacts on health care delivery, especially for self-governing Tribes.

The Indian Health Service (IHS) Tribal Self-Governance Program recognizes that Tribal leaders are best positioned to understand and address the health care needs of their communities. Programs like the Indigenous Leaders in Governance, launched in 2021, offer customized training to elected Tribal leaders, focusing on traditional forms of Indigenous governance and Native nation rebuilding principles (Indian Health Service, 2016c).

Technical advice and support for Tribal and urban health leaders is also provided by or available from organizations such as the NCAI, SGCETC, NIHB and NCUIH. Leaders are exposed at conferences to new knowledge shared in plenary and breakout sessions, and they are also provided with tools, written submissions, and policy papers to give them advice or to prepare them for giving testimony at hearings. For me this has resulted in a network of highly skilled and well-informed Tribal health leaders across the country.

4.9.2. Tribally-led leadership development programs

Tribes themselves have also developed initiatives to help improve the capability of their Tribal workforces. The Alaska Native Tribal Health Consortium (ANTHC) for instance developed leadership programs to help grow their Alaska Native leaders. The Alaska Native Executive Leadership Program (ANELP) developed with the Alaska Pacific University (APU) is designed to give students in-depth knowledge in key functional business areas. The ANTHC has also graduated many staff from its two leadership programs: Pathways to Leadership and Leadership Excellence through Determination (LEAD). As well as tailored local solutions such as the ANTHC models, the Self-Governance, and Communications Education Tribal Consortium (SGCETC) provides training and education in Self-Governance (Alaska Pacific University, 2024).

4.9.3. Building the frontline health care workforce

The ANTHC also worked with academic institutions to develop three unique and specific health aide programs tailored for Alaska Native workers who work primarily in rural and remote communities of Alaska – the Community Health Aide Program (CHAP), the Dental Health Aide Therapists (DHAT) and Behavioral Health Aides (BHA) (Alaska Native Tribal Health Consortium, nd-b; Wetterhall, 2010).

Tribes themselves also invest in growing their own workforces as well as designing their own programs. The Navajo Nation for instance wants to attract a lot of its own qualified professionals to come home to work for the Tribe. For this reason, in 2019 they set up a $50 million

Scholarship and Endowment Fund from their own Navajo resources (Nez & Lizer, 2019). Higher education is of such importance to the Nation that they established the Office of Navajo Nation Scholarship and Financial Assistance (ONNSFA), which provides enrolled members of the Navajo Nation an opportunity to achieve their educational goals (Office of the Navajo Nation, 2019). In 2018 alone, the ONNSFA awarded more than $24 million in financial aid and scholarships to approximately 6,000 students seeking a college degree or certificate.

4.9.4. Accessing Information about Knowledge Development and Opportunities

There are also workforce development initiatives which are government-led. The national Technology Transfer Centers (TTCs), funded by the Department of Health and Human Services (Substance Abuse and Mental Health Services Administration, 2021), act as clearinghouses for training, information, research, tools, and resources in specific health system areas.

The Indian Health Service offers scholarship programs (Indian Health Service, 2000) with the purpose "to increase the number of Indians entering the health professions:" Health Professions Preparatory Scholarship; Health Professions Pre-graduate Scholarship; and the Health Professions Scholarship.

4.9.5. Academic programs

Supporting the effort to grow the American Indian / Alaska Native (AI/AN) workforce, are Universities who work to better attract and meet the needs of AI/AN students and to support them into health careers. Two such examples are the "Indians into Medicine" (INMED) program at the University of North Dakota (University of North Dakota, 2021), and the Recruitment & Retention of American Indians into Nursing (RAIN) program (University of North Dakota, nd).

4.9.6. Indian Health Service strategies

The Indian Health Service offers grants and scholarships through their American Indians into Nursing Program works to increase the number of nurses, nurse midwives, nurse anesthetists

and nurse practitioners who deliver health care services to American Indian and Alaska Native (AI/AN) communities. The IHS Loan Repayment Program (LRP) for instance awards up to $40,000 per year for the repayment of qualified student loans in exchange for an initial two-year service obligation to practice full time at an Indian health program site (Indian Health Service, 2021b).

4.9.7. Government Preferencing Policy

One of the workforce policies I was particularly impressed by was the Indian Preference Policy (Indian Affairs, 2004). The Indian Preference policy is a tool used by the Bureau of Indian Affairs (BIA) in the U.S. Department of the Interior (DOI) and the Indian Health Service (IHS) in the U.S. Department of Health and Human Services (HHS), and authorized by Congress, to encourage qualified American Indians and Alaska Natives to seek employment with the BIA and IHS.

4.9.8. Summary

CSF 5: Qualified Workforce reinforces how Tribal leaders involved in TSG can benefit from support and education, including programs like the Indigenous Leaders in Governance and technical advice from organizations such as NCAI, SGCETC, NIHB, and NCUIH. This has resulted in an increasing network of skilled and well-informed Tribal health leaders across the country.

Tribally-led initiatives play a crucial role in workforce development. For example, the Alaska Native Tribal Health Consortium (ANTHC) has developed leadership programs and specialized health aide programs tailored for Alaska Native workers in rural and remote communities. Similarly, the Navajo Nation has established scholarship funds and financial assistance programs to encourage its members to pursue higher education and return to work for the Tribe.

Government-led initiatives also contribute significantly to workforce development. These include the Technology Transfer Centers (TTCs), Indian Health Service scholarship programs, and the Indian Preference Policy, which encourages qualified AI/AN individuals to seek employment with the Bureau of Indian Affairs and Indian Health Service. Academic institutions partner with Tribes to offer specialized programs, such as the "Indians into Medicine" (INMED) and the Recruitment & Retention of American Indians into Nursing (RAIN) programs at the University of North Dakota. These programs aim to increase the number of AI/AN professionals in various health fields.

In conclusion, CSF 5 implies a comprehensive and collaborative approach to developing a qualified workforce for TSG. This approach involves Tribal, governmental, and academic efforts, addressing both leadership and frontline TSG worker development, and emphasizing the importance of culturally appropriate education and training programs

4.10. CSF 6: Sustained communications and inclusion

A vital element of Self-Governance is the ability of Tribal leadership to stay informed so that they can perform their roles adequately. Additionally, there is a need for the wealth of information that circulates throughout the Tribal health system, to be collected and disseminated among the Tribes, and with Federal government, partners, and suppliers.

4.10.1. Tapping into communication channels

To help me understand first-hand how and what information is shared, I registered with key mail lists to ensure I received the same regular updates that stakeholders within TSG received. This included the regular email communiqué to Tribal organizations and other stakeholders from the national organizations such as NCAI, NIHB and SGCETC, but also a number of other mediums for sharing of information. The SGCETC for instance shares key documents which relate to TSG such

as submissions and testimony which Tribal leaders have given at Senate and Congressional hearings (Self-Governance Communication and Education Tribal Consortium, 2018b).

They also maintain a calendar identifying dates for TSG conferences, Advisory Group meetings, TSG Senate, Legislative and Congressional hearings, and training sessions. This enables Tribal leaders to make decisions about which meetings and hearings they either want to appear at, observe or follow. The SGCETC also acts as a repository for key events and announcements from the DOI and DHHS so that Tribal leaders can stay informed, and often the Federal agencies will draw on the SGCETC's capability, as well as other national organizations, to quickly disseminate information to all Tribal leaders.

Figure 10: One of the TSG Conferences Organized by the SGCETC I Attended

Note. Photo credit: Mara Andrews

Typical size of the conference and attendance by Tribal leaders and Health administrators.

4.10.2. The Indian Health Service Role in Communication

The IHS also plays a key role in communicating information to Tribes and receiving Tribal perspectives to influence the design and delivery of their core functions. The mechanisms that the

IHS uses to achieve this are varied such as the use of the Advisory Committees or topic-specific working groups, such as the Budget Formulation Working Group (Indian Health Service, nd-a).

Another key method of sharing information and maintaining communication between IHS and Tribal leaders is the use of Director 'Listening Sessions.' These sessions involve the Director of the IHS setting aside specific time during site visits, at conferences and Board meetings, just to listen to Tribal leaders. There is no agenda for these sessions and Tribal leaders are able to raise any issue with the Director (Indian Health Service, 2023). I personally attended some of these Listening Sessions over the years and I was impressed by the way in which this technique made the Director available as the most Senior Executive of the IHS, to Tribal leaders to raise issues without a managed agenda. I saw these Listening sessions as both a risk management strategy to draw out issues that may be percolating or unknown, and a means of providing a respectful face to face opportunity for leaders to get one-on-one time with the Director for their specific issues.

The IHS also has a Tribal Consultation Policy as it is required to do as an operating division of the DHHS. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and Executive Orders (EO) 13175 in 2000 (Clinton, 1994; US Government, 2000). The goal of this policy includes, but is not limited to, "assisting in eliminating the health disparities faced by Indian Tribes, ensuring that access to critical health and human services and public health services is maximized to advance or enhance the social, physical, and economic status of Indians; and promoting health equity for all Indian people and communities." The Tribal Consultation Policy reflects the U.S. Government-to-Government relationship with Indian Tribes and typically asserts that authentic and effective consultation should result in information exchange, mutual understanding, and informed decision-making on behalf of the Tribal governments and the Federal Government.

One more formal method of communication that I have witnessed were the 'Dear Tribal Leader Letters' (Sweeney, 2021). The Dear Tribal Leader Letters (DTL) serve as formal written

mechanisms to notify Tribal Leaders from all federally recognized Tribes of consultation activities (Indian Health Service, 2023). It is also used to invite Tribal Leaders to events or meetings and to provide other critical information to Tribes. These are distributed widely to leaders across the country *via* mass email distribution.

4.10.3. The Role of National Institutions in Communications

Tribes and national organizations use media, social media, and news items to disseminate information and to communicate with Tribes and each has an active website. Resources such as fliers, pamphlets, guidelines, Dear Tribal Leader letters and statements / submissions are distributed through these web-based platforms for all stakeholders to access as well. As a registrant on the NIHB mail list for instance, I have received, for example, several updates and communications involving:

- Virtual conferences and webinars;
- Notifications of Grant Funding opportunities;
- Announcement of Tribal Consultation events;
- The 'Washington Report' which provides Federal government and legislative updates;
- Notifications on resources available to Tribes that have been recently released (e.g., guidelines for caring for Elders);
- Legislative Alerts: notifications of new legislation being introduced, hearings, submissions, testimonies, or updates to current legislation.

4.10.4. Summary

CSF 6: Sustained communications and inclusion aims to keep Tribal leadership informed and to facilitate the flow of information throughout the Tribal health system.

There are three key aspects of communication: ***Diverse Information Channels*** using various platforms such as email lists, calendars, and repositories managed by organizations like SGCETC provide regular updates and key documents to Tribal leaders; ***IHS Communication Strategies*** The Indian Health Service uses methods such as Advisory Committees and Director Listening Sessions, and operate a formal Tribal Consultation Policy to engage with Tribes and gather their input. ***National Organizations' Role*** Tribes and national organizations utilize media, social media, and web-based platforms to disseminate information on funding opportunities, legislative updates, and resource availability. These communication strategies collectively ensure that Tribal leaders remain informed, can participate in decision-making processes, and have access to crucial resources. Sustained communications are key.

4.11. CSF 7: Infusion of Indigenous culture

There are many cultures, practices and languages among Native Americans and Alaska Natives. It is important in a self-governing environment that all Tribes can express their own culture as they prefer.

4.11.1. Native Languages

According to Interpreters and Translators Inc. (2020), Native American languages in the U.S. have succumbed to linguicide over time and state that approximately 300 languages were spoken in the U.S. before colonialism. Today, approximately 167 Indigenous languages are spoken in the U.S., and it is estimated that only 20 of these languages will remain by 2050 (Bureau Works, nd). Navajo is the most spoken Native American language, with 170,000 speakers (U.S. Department of Education et al., 2016).

The Tuba City Regional Health Care Corporation (TCRHCC) in the Navajo territory is an example of one Tribally governed health entity serving around 75,000 native people that has a dedicated Office of Culture and Language Resources. This office has a strong focus on increasing

the number of staff who are proficient in the Navajo and/or Hopi languages and so far, they have 60+ Health Care Interpreter Liaisons throughout the hospital (Personal communication during site visit, 2019).

4.11.2. Tribal institutions

Tribal institutions are often designed around historical models of Tribal organization and adapted to be recognizable within the legal structure requirements of the U.S. For instance, in Alaska, the Tribal organization is founded on small villages who then come together within regional Alaska Native Corporations and health entities, and then State-wide entities such as the Alaska Native Health Board with a political focus and the Alaska Native Tribal Health Consortium (Alaska Native Tribal Health Consortium, 2019). Members of governance of local, regional, and Statewide entities are drawn from the different parts of Alaska so that the voices are representative of the different villages, languages, and cultures. In other parts of the U.S., Tribal structures are also reflective of the historic cultures and Tribal social structures.

At the Navajo Nation, the largest in the U.S., the Navajo Nation Council Chambers hosts 88 council delegates representing 110 Navajo Nation chapters or communities. The council meets four times per year, with additional special sessions, at the Navajo Nation Council Chamber in Window Rock, Arizona. The council is composed of 24 district delegates representing 110 municipal chapters within Arizona, New Mexico, and Utah. The current structure of the council was established by the Title II Amendments of 1989, which created the three-branch government system (Navajo Nation Council, nd).

4.11.3. Tribal Customs and Traditions

The use of Tribal customs, protocols, dress, and language in the day-to-day business of self-governing Tribes was something I was constantly exposed to during my interactions with them. I saw this in the way protocols were conducted at TSG conferences through such practices as use of the local Tribal language for wherever the conference was being hosted; acknowledging host Tribal

Nations; opening prayers by Elders of local Tribe(s) and displaying of sovereign flags. Often conference participants attended conferences in traditional dress or clothing and many of the exhibitions and markets at the conferences sold handmade authentic cultural dress, jewelry, and artwork. Indigenous businesses were well supported at TSG conferences. When visiting individual Tribes, I saw culture embedded in building design, use of bilingual signage, display of local Tribal artwork and monuments, and use of the language in pamphlets, newsletters, and newspapers.

4.11.4. Tribal Methods of Negotiation and Conflict Resolution

One interesting feature of dispute resolution within and between Tribes was the use of Tribal processes for conflict resolution, or what was often called 'peace-making.' For instance, in Alaska the large number of Tribal communities involved in the State-wide consortium meant there needed to be a mechanism for dispute resolution. To manage this, local leaders developed their own dispute resolution process through the creation of the Tribal Caucus. According to the Alaska Tribal Compact Handbook (Alaska Legislature, 2021), which outlines ground rules for negotiations and dispute resolution for negotiating the Alaska Tribal Compact agreement, the Tribal Caucus does not necessarily exist to focus on resolving disputes, but more to take a strengths-based approach to reach consensus on key issues. The goal is for consensus to be reached so that Tribes can return to the table with Federal negotiators and speak with one voice through their designated negotiators.

4.11.5. Traditional Medicines and Healing

Across the U.S. there are several examples of the practice and revitalization of traditional medicines and healing practices being integrated into western models of health care. Across the Navajo Nation for instance, I was able to see traditional sweat lodges based on the campuses of medical centers and hospitals. I saw traditional medicine gardens and met healers, Elders, traditional knowledge-keepers, language experts and cultural advisors who were all key members of Tribal health care teams. I also saw sweat lodge hogans in the backyards of many homes across the Navajo Nation (Colmant & Merta, 1999).

At the Southcentral Foundation in Alaska, a traditional healing clinic is a key program embedded within their large primary care center in Anchorage (Huhndorf, 2017). There are many more examples of the integration of traditional healing within health care and especially so within systems managed by self-governing Tribes who have the right and freedom to make these kinds of decisions and investments.

4.11.6. Culturally Based Service Models

Several self-governing Tribes have been able to design and implement their own culturally based service models. One such model is the well-known Nuka System of Care developed by the Southcentral Foundation (SCF) in Alaska which has been written about (Gottleib et al., 2008) and presented by SCF globally. The SCF Nuka System of Care is a relationship-based, customer-owned approach to transforming health care, improving outcomes, and reducing costs. 'Nuka' is an Alaska Native word that means "strong, giant structures and living things." Other examples are the Store Outside Your Door (Alaska Native Tribal Health Consortium, 2009) and the Special Diabetes Program for Indians (SDPI).

4.11.7. Summary

CSF 7: Infusion of Indigenous culture: Infusion of Indigenous culture into the Self-Governance environment is not something that Tribes have *had* to do. They express and live their culture across the continuum of health care because it is who they are; it is the expression of their identity; and it is an expression of their sovereignty. Through language, cultural protocols, program design and delivery, displaying flags of sovereignty, using traditional methods for structural organization and relationship management – all Tribes have applied the cultural lens in ways that work best for them.

This factor encompasses various aspects of Indigenous life, including language preservation, institutional structures, customs and traditions, conflict resolution methods, traditional medicine, and culturally-based service models.

Language preservation efforts, such as those at the Tuba City Regional Health Care Corporation, demonstrate the importance of maintaining Indigenous languages in health care settings. Tribal institutions, like the Navajo Nation Council, reflect historical models of organization while adapting to U.S. legal structures. The integration of customs and traditions in day-to-day operations, from conference protocols to building design, reinforces cultural identity.

Unique approaches to conflict resolution, such as Alaska's Tribal Caucus, showcase how Indigenous methods can be effectively applied in modern governance. The incorporation of traditional medicines and healing practices, including sweat lodges and traditional healing clinics, demonstrates the holistic approach to health care in self-governing Tribal systems.

The development of culturally-based service models, like the Nuka System of Care, illustrates how Self-Governance allows Tribes to create innovative, culturally-appropriate approaches to health care delivery. These elements collectively contribute to the success of Tribal health care Self-Governance by ensuring that services are culturally relevant, community-owned, and aligned with Indigenous values and practices.

I have included it as a factor to stress the importance of proactively enabling cultural infusion across all of the other TSG success factors that I have included in my framework.

4.12. CSF 8: Flexible funding and revenue sources

One of the most critical factors for TSG is the need for consistent and equitable funding and revenue sources for Tribes who are governing their own health care systems.

4.12.1. Funding as a Federal Trust Responsibility

The basis for advocacy for an equitable budget by Tribes is at its core based on the Federal Trust responsibility, the promise to provide health services to American Indians. It is not simply an

equity issue. It is about the keeping of promises made in Treaties. The National Tribal Budget Formulation Workgroup describes this well:

> *"The Federal promise to provide Indian health services was received in good faith by our ancestral Tribal leaders to lay the foundation for peaceful co-existence of our great nations. By giving up Tribal lands, the United States were able to prosper and build great wealth, leaving First Americans to try to build a life as domesticated nations in land reserves carved out by the President. Since the earliest days of the Republic, all branches of the Federal government have acknowledged the nation's obligations to the Tribes and the special Trust relationship between the U.S. and American Indians and Alaska Natives. The U.S. assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 legislatively affirmed this trust responsibility." (National Tribal Budget Formulation Workgroup, 2020 p.3; U.S. Senate, 1921)*

4.12.2. Underfunded IHS Means Underfunded Self-governing Tribes

This issue remains one of the most critical for self-governing Tribes in the U.S. To address this issue a National Tribal Budget Formulation Workgroup was formed by the IHS and Tribal leaders with representatives from Tribes from all 12 IHS regions, from urban organizations, from the NIHB and from the IHS. They have been established and working as a national workgroup since the late 1990s.

In the most recent report that (National Tribal Budget Formulation Workgroup, 2021), the workgroup advocated for the Government to recognize and address the continuing deficits in the IHS budget.

Recently the Tribes achieved a significant milestone in their history of fighting for much needed resources. Announced on the 10th of March 2021, the American Rescue Plan (Covid-19)

awarded a staggering $31.2 billion to Native American and Alaska Native Tribes from a total $1.9 trillion package (Native News Online, 2021). It is the largest amount of money ever allocated for American Indian/Alaska Native programs in history.

Some of the other key levers for other sources of funding and revenue outside of the IHS core funding are discussed below.

4.12.3. Access to Grants

Outside of the core funding from the IHS, there are other revenue sources which Tribes can access such as, grants for workforce development (e.g., scholarships) and research (grants are available to Tribal Epi Centers and other Tribal programs). These latter grants also help to build up the quantum of Tribally owned and governed health data and information (Tribal EPI Center Public Health Infrastructure, nd).

4.12.4. Access to Third Party Revenues

The Affordable Care Act 2010 entitled Tribes to claim reimbursements from third party revenue sources including the Medicare and Medicaid (National Indian Health Board, nd-b), private health insurance and Veterans Administration programs, without impacting their baseline IHS funding. This has enabled some Tribes to expand their service provision to non-citizens and to attract more revenues. For some the increase in revenues through third party claims has been significant. For example, Tuba City Regional Health Care Corporation identified in its 2018 annual report that 65% or around $200 million of their total revenues came from third parties and private insurance while 31% came from the Indian Health Service (Tuba City Regional Health Care Corporation, 2017).

4.12.5. Funding of Overhead (Contract Support Costs)

Contract Support Costs (CSC) have been a bone of contention for many years under the TSG program and remain a critical element of ensuring effective and sustainable TSG arrangements.

Contract Support Costs are the overhead and administrative costs incurred in the governance and management of health care programs and are separate to the costs of delivering the program itself to patients and citizens. In June 2012, the Supreme Court—for the second time—held the government liable for these contract underpayments (Hobbs, 2020) and following this decision, the Obama administration announced a settlement to fund contract support costs. Since then, the Federal administrations have resolved a number of individual disputes with Tribes and Tribal entities. The IHS alone paid $705.5 million on 947 contract support costs claims as of May 2015 (Indian Health Service, 2016b).

4.12.6. Joint Venture Construction funding

One of the innovative ways that the Indian Health Service, which has limited capital funding, and Tribes have worked around the shortage of capital funding, is the use of the Joint Venture Construction program. In essence it allows the Tribe to build the health facility and want and need, while the IHS provides a guarantee of service funding to operate services within the facility. This enables the IHS to support ongoing service provision to communities, in an environment where they have limited funds for capital infrastructure. One such project was announced in 2015 (Public Radio Tulsa, 2015) for the Cherokee Nation

> TAHLEQUAH, Okla. (AP) — The Cherokee Nation has been awarded an Indian Health Service Joint Venture Construction Program project that will add a new facility to the Tribe's W.W. Hastings Hospital in Tahlequah. The agreement calls for the Tribe to build the 250,000-square-foot facility and the IHS to provide up to $30 million a year for 20 years for staffing and operations. The Cherokees were among the top three Tribes selected from a pool of 37 applicants. (Tribal Business News, 2015)

In fact, in 2023, I was fortunate to visit the actual facility which was built as it is now operational.

Figure 11: Image of the new Cherokee Medical Centre funded by the Joint Venture program with IHS

Note. Image source: Photo by Mara Andrews

4.12.7. Access to and Retention of Federal Benefits

Another key lever that was negotiated by TSG leadership was the ability for Tribes to retain access to Federal waivers, discounts, and benefits that the IHS is entitled to, even when the Tribes assume control of programs from the IHS. As the IHS is part of the U.S. Public Health Service, the IHS is entitled to specific benefits and waivers. For instance, the Federal Tort Claims Act 1946 (FTCA) is the Federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United States, to file claims against the Federal government ("Federal Tort Claims Act," 1946). When a Tribe elects to self-govern the IHS programs, the Tribe retains the status as a member of the U.S. Public Health Service and consequently Tribal employees are also covered by the Federal government under the FTCA. The fact that Tribes do not have to maintain malpractice insurance or to defend claims, is a significant cost-saving for Tribes.

4.12.8. Summary

CSF 8: Flexible funding and revenue sources focuses on the crucial role of funding and revenue sources in effective Tribal Self-Governance in health care. This factor has its roots in the

Federal Trust Responsibility, which obliges the U.S. government to provide health services to Tribes based on historical treaties and agreements. This section highlights the ongoing challenge of underfunding in the Indian Health Service (IHS) and its impact on self-governing Tribes. To address funding challenges, Tribes have access to various mechanisms beyond core IHS funding, including grants, third-party revenues (e.g., Medicaid, private insurance), and innovative programs like the Joint Venture Construction program. The resolution of Contract Support Costs disputes has been a significant achievement, ensuring Tribes receive funding for administration and overheads.

Recent developments, such as the unprecedented $31.2 billion allocation to Tribes through the American Rescue Plan, demonstrate the potential for substantial funding increases. However, the ongoing need for advocacy and strategic approaches to secure and manage diverse funding sources remains critical. This section underscores the importance of Tribes retaining access to federal benefits and waivers, such as coverage under the Federal Tort Claims Act, which provides significant cost savings.

TSG can only work if it is appropriately and fairly resourced. The proactive and strategic initiation of the National Tribal Budget Formulation Workgroup, and their resulting annual reports on the extent of the funding gap for the IHS, is inspiring, innovative and essential. They can not only talk about the funding gap now, but they can track it. By grounding budget negotiations in Treaty promises and sovereignty, the AI/AN Tribes may still not have the success they desire, but they certainly have the sound principles and foundations upon which to have these conversations with the Federal government. Overall, CSF8 emphasizes that effective Tribal Self-Governance relies on a combination of adequate core funding, diverse revenue streams, and the flexibility to allocate resources according to Tribal priorities and needs.

4.13. CSF 9: Robust data and measurement

The final critical success factor that I identified for successful TSG relates to data, information, and measurement of progress.

4.13.1. Tribal Data Capacity

The NCAI developed a white paper on Tribal Data Capacity as a broad issue. While not health-specific, the issues raised in this paper are very relevant to the TSG environment which states:

> *"Like other nation states, AI/AN Tribes are decision-making entities that need reliable information for planning and development. Tribes still rely on incomplete or inadequate data about their citizens and resources. The lack of reliable planning data is only one symptom of the data gap in Indian country. AI/AN populations remain both hard-to-count and hard-to-reach. They experience vast data inequities, such as being notable for the largest Census undercount of any racial or ethnic group, misidentification in vital and administrative records, and a persistent digital divide." (National Congress of American Indians, 2017, 2018, p.1).*

Furthermore, the NCAI paper affirms that the demand for Indigenous data sovereignty, that is, the right of a nation to govern the collection, ownership, and application of its own, is a growing effort (National Congress of American Indians, 2018).

4.13.2. Health Information Technology (HIT)

Robust Tribal data is needed by self-governing Tribes on health issues for functions like advocacy for policy and funding, or measuring health service utilization, health impacts and health outcomes. There are several important themes that relate to Health Information Technology (HIT), its' current state within the Indian Health Service and among Tribes, and the need for a strategy moving forward t/o build a sustainable HIT platform for the future.

Two key elements of the HIT for Tribes are the current Resource and Patient Management System (RPMS) of the IHS, and the IHS Health IT Modernization Project (Indian Health Service, nd-b). The IHS system that is used to collect and record health-related data is the Resource and Patient Management System or RPMS (Indian Health Service, 2020). The IHS has created the HIT project inclusive of Tribal representatives to review the RPMS and develop a strategic approach to HIT in the future.

4.13.3. Reporting to Government

The NCAI produced a policy advice paper for Tribal leaders stating that a "Tribe's collection and maintenance of data at its own initiative for its own purposes should be the primary focus of any analysis of Tribal data capacity" (National Congress of American Indians, 2018). A significant role of Tribal data capacity is to satisfy the reporting requirements of various Federal agencies that provide funds to Tribes. The NCAI conducted an analysis on the volume of data and time that Tribes spend to meet Federal reporting requirements and determined that due to the extensive requirements imposed by each Federal agency, and the absence of coordination among them has made it challenging to develop an estimate of the total scope of the Federal reporting requirements imposed on Tribes.

4.13.4. A Tribal Solution to Self-Governance Reporting

The Tribal Data Exchange (TDE) is designed to meet the minimum dataset for Self-Governance (Chickasaw Nation, 2015). The TDA is an existing Tribal data system which is able to meet budget formulation, fund distribution, program management, and reporting needs of Direct Service, 638 Contract, and Self-Governance Tribes. TDE is housed and managed by the Chickasaw Nation. TDE allows Tribes to keep their data private; is designed to transform data at its lowest level into useful information for timely management decisions. TDE can be used by Tribes to meet the needs of Tribal communities and at the same time advance Tribal/Federal partnerships to meet the needs of Tribal communities and at the same time advance Tribal/Federal partnerships.

4.13.5. Tribal Epidemiology Centers (TECs)

A key group of stakeholders in the data and information domain are the Tribal Epidemiology Centers (TECs) commonly known as Epicenters. These were established by legislation and are funded by the IHS and the National Institutes of Health (Alaska Native Tribal Health Consortium, nd-a; Southern Plains Tribal Health Board, nd). TECs play a critical role in building public health capacity among AI/AN communities and provide a variety of public health services including data dissemination, surveillance, applied epidemiological studies, training, responses to public health emergencies, technical assistance, and disease control and prevention activities. TECs also support national public health goals by working to improve data for GPRA ("Government Performance and Results Act," 1993) reports.

4.13.6. Population Health Measures – Government and Tribal

A Baseline Measures Workgroup was formed in 1994 to develop and recommend a set of baseline measures for AI/AN communities and they presented their final report in 1996 (Baseline Measures Workgroup, 1996). The workgroup was composed of health professionals from IHS and Tribes and sought to develop baseline measures at the request of the Director of the IHS to monitor the performance of the health care program. Not all proposed measures apply to all Tribes. The workgroup developed six categories including 150 measures however these are recommended on a scale so that smaller centers do not report as much as larger centers.

I have not found significant evidence of the baseline measures being fully implemented, despite the positive work done by the workgroup to develop them, with the exception of this paper which discusses implementation in terms of brain development in AI/AN (White et al., 2023). Early adoption and implementation of these kinds of measures by all Tribes by consensus, would have provided a sound foundation for preventing many of the Health Information Technology and reporting challenges mentioned in this section of this report.

4.13.7. Research Projects

Since 2001, the Native American Research Centers for Health (NARCH) initiative, administered by the National Institutes of Health and the Indian Health Service, has funded numerous Tribal academic research partnerships. The NARCH initiative goals are to increase the capacity of Tribes and academic centers to conduct research, reduce distrust and provide training to reduce health disparities in AI/AN communities while also building Tribal research capacity and oversight.

4.13.8. Telehealth Technology

Telehealth tools enhance timely consultation, diagnosis, and treatment and avoid the costs of travel by either patients or providers. One such example of the ability of telehealth services to improve health equity is the Alaska Federal Health Care Access Network solution (Patricoski, 2004). Patricoski notes that telehealth tools are able to effectively bridge time and distance, helping maximize the productivity and efficiency of available health care providers. The Alaska Federal Health Care Access Network (AFHCAN) telehealth solution has been operational since 2001 and provides telehealth services to 248 sites across Alaska (Khan et al., 2012). In the past decade, more than 70,000 telehealth cases have been created within ATHS alone, for both primary and specialty care.

4.13.9. Summary

CSF 9: Robust data and measurement focuses on the role of data and measurement in effective Tribal Self-Governance in health care. This factor encompasses a number of aspects, including Tribal data capacity, health information technology, reporting requirements, and specialized data solutions. This section highlights the challenges faced by Tribes in obtaining reliable data and meeting extensive federal reporting requirements. It also presents solutions such as the Tribal Data Exchange and the establishment of Tribal Epidemiology Centers. The importance of population health measures, research initiatives, and telehealth technology in supporting data-driven

decision-making is also discussed. While Tribes have made significant progress in this area, ongoing efforts are needed to ensure data sovereignty, improve data quality, and leverage information for better health outcomes. Robust data and measurement systems are essential for Tribes to effectively plan, manage, and advocate for their health care needs, ultimately contributing to the success of Tribal Self-Governance in health care.

4.14. Uncertainties with the Framework

While the initial Critical Success Factor (CSF) framework for effective Tribal Self-Governance (TSG) presented in this chapter is grounded in extensive observational data, document analysis, and personal experience gathered over nearly two decades, there are several uncertainties and potential limitations that should be acknowledged:

- **Comprehensiveness:** Although the nine factors identified cover a broad range of important aspects for effective TSG, there may be additional critical factors that have not been captured. The complex and evolving nature of TSG means that some new elements might have been overlooked;
- **Relative Importance:** The current framework does not provide insight into the relative importance or prioritization of the nine factors. It's possible that some factors may have a more significant impact on TSG success than others, which is not reflected in the current model;
- **Interrelationships**: While the factors are presented as distinct elements, there are likely complex interrelationships and dependencies between them, interacting with or influencing each other.

- **Contextual Variations:** The framework is based on observations and experiences across multiple Tribes and regions. However, it may not fully account for the diverse contexts, sizes, and specific challenges faced by individual Tribes;
- **A Snapshot in Time:** The original 2018 framework represents a snapshot based on data collected up to 2017. Given the dynamic nature of TSG and policy environments, some aspects of the framework may already be subject to change;
- **Quantitative Validation:** While the framework is based on extensive qualitative data and observations, it lacks quantitative validation. The absence of measurable indicators or metrics for each factor makes it challenging to objectively assess their impact on TSG success. This process is likely beyond the scope of the current research;
- **External Validity:** The framework is primarily based on experiences within the United States TSG context. Its applicability to Indigenous Self-Governance models in other countries or contexts is uncertain and requires further investigation. A focus on relevance to the New Zealand context will be given.
- **Stakeholder Perspectives:** The framework largely reflects the author's synthesis of observations and collected data. It may not fully capture the diverse perspectives of all stakeholders involved in TSG, including Tribal citizens, health care providers, and government officials. The validation study could address this shortcoming;

These uncertainties highlight the need for a robust validation process, which is the focus of the subsequent chapter. Through this validation, the framework can be refined, expanded, or modified to address these limitations and provide a more comprehensive and reliable tool for understanding and implementing effective Tribal Self-Governance.

4.15. Chapter summary

This chapter presents the development and description of a critical success factor (CSF) framework for effective Tribal Self-Governance (TSG) in health care. I have described the process of gathering information over an extended time period (1999-2017) through various means, including literature review, document analysis, and extensive observational data collection at conferences and site visits. A brief review of other Indigenous governance models and important characteristics was conducted, and this affirmed the relevance of my draft framework as there was strong alignment of my factors with those identified in another research.

The core of the chapter is dedicated to describing nine critical success factors identified I have identified: Policy and Political Will, Successful Partnering, Accountability for All, Unified Tribal Leadership, Qualified Workforce, Sustained Communications and Inclusion, Infusion of Indigenous Culture, Flexible Funding and Revenue Sources, and Robust Data and Measurement. Each factor is explained in detail, with supporting evidence from the author's research and observations. The factors are supported by evidence from the Native American literature (Brayboy, Fann, et al., 2012; Chino & DeBruyn, 2006; Khan et al., 2012; Rainie et al., 2017; Donald Warne & Linda Bane Frizzell, 2014). It is these nine factors and the overall framework which are the subject of a validation process described in the following chapter.

CHAPTER 5: VALIDATING THE CRITICAL SUCCESS FACTOR (CSF) FRAMEWORK

5.1. Introduction

This chapter presents the major analysis and findings of my research. I present the method, and a description of the data collected to validate and refine the framework.

5.2. Applying the Framework Analysis Method

To verify and validate the Framework of Critical Success Factors for Tribal Self-Governance in health care in the U.S., I have undertaken an analysis underpinned by kaupapa Māori principles, a kaupapa Māori standards framework, and based upon the U.K. National Centre for Social Research's Framework Analysis Model (NCFAM) (Gale et al., 2013). The NCFAM is well-suited for managing and analyzing qualitative data from multiple sources and provides the main method here. A deductive analysis is performed using the Initial CSFs as the coding system following the recommended processes of Braun & Clark (Braun & Clarke, 2021).

5.2.1. Data Collection

I have used three primary data sources. First, semi-structured interviews with 10 Tribal leaders were undertaken. The sample of respondents is described in full in section 0. Second, a comprehensive literature review has been completed and the results are presented in section 5.3. Third, first-hand observations of recent Tribal meetings are presented in section 5.3.1. Each of these sources provide data for the analysis.

5.2.2. Analytical Approach

The NCFAM has been applied to primarily analyse the interview data. This method is particularly appropriate for this study as it allows for both a priori and emergent concepts to be incorporated into the analytical framework (Gale et al., 2013). Using the framework allows me to

engage with the data reflexively, particularly in terms of themes which may be outside the initial framework.

5.2.3. Analysis Process

The analysis has followed the five key stages of the Framework Method (Gale et al., 2013). The first stage was a process of familiarization with the raw data. I personally undertook all the interviews and also produced the transcripts. In this way I was able to become very familiar with the data set. Each respondent was asked a series of questions before seeing the initial CSF framework, and then after seeing the framework. As there were only ten interviews, I was able to understand the details of the interviews in some depth, and recall was not onerous. I undertook the analysis manually as the volume of data did not justify the use of a Qualitative Software package.

The second stage involved identifying a (Braun & Clarke, 2021) framework. As I had chosen to undertake deductive analysis using the initial CSF framework the thematic framework was obvious. So, the nine factors were used to code the data. However, I also used additional codes to identify data which addressed the framework as a whole, and in order to identify additional themes inductively which were not satisfied by the CSF theming. In this way emergent issues raised by respondents, and new analytical themes arising from the recurrence of views or experiences were able to be managed.

The third stage was indexing – the systematic application of the thematic framework to all data. Again, the volume of data allowed me to undertake this stage manually, using spreadsheets and documents together with a running notebook of handwritten memos to record observations and impressions along the way.

The fourth stage is charting. Here I created thematic matrices (spreadsheets) where data is summarised by theme category for each ‘case’ (Tribal leader or literature source). This allows for both case-based and theme-based analysis.

The last stage is interpretation. As the interpretation is guided by the initial framework the interpretation examined how well the data fitted each of the CSFs and framework as a whole. The interpretation phase allowed for refinement and adaptation of the framework based on the analysed data. As well as interpreting the themes, I was able to interpret the 'cases' (each of the interviews and literature) to find commonalities and differences in relation to the CSF framework. This part of the analysis also enabled me to identify possible negative cases, in this setting negative cases were contradictions to the CSFs, or possibly the identification of new factors not otherwise seen. The literature on FAM cautions that when using FAM deductively it is important to remain open to new insights which may emerge from the data even if they are not consistent with the deductive codes or themes.

5.2.4. Cultural and Ethical Considerations

The validation process employed kaupapa Māori approaches, as outlined in Chapter 3. This involved adhering to local protocols when engaging with Tribal and Federal leaders, particularly by honoring the time they dedicated for interviews. In keeping with Māori customs, a small koha, specifically a New Zealand bone carving, was presented to each participant as a token of appreciation for their contributions.

The trust established over 12 years of prior relationships between participants and the researcher (shaped and strengthened while living in North America), significantly enhanced the willingness of participants to engage. This shared indigeneity fostered a mutual understanding that the study's purpose was genuine and aimed at benefiting Indigenous communities, rather than exploiting them. Adhering to the 'do no harm' principle was paramount throughout the research.

Ethically, it was essential to balance anonymity and confidentiality. Participants consented to join the study, and to ensure their anonymity, labels (e.g., Tribal vs. Federal) were used to protect individual identities while still capturing their perspectives. Additionally, each participant was provided with a copy of the final draft of the thesis for review before submission to the University,

allowing them the chance to challenge or request changes to any content they found offensive or inaccurate. Notably, no changes were requested during this review process.

5.2.5. Validation Strategy

To enhance the rigor and validity of the analysis I adopted the following strategy. I coded the data multiple times focusing, for example, on whether data could fit more than one code. A peer reviewer (my supervisor) then independently reviewed a subset of the data to check reliability of the coding process. Next, triangulation of data sources (interviews, literature, observations) was used to corroborate findings. The literature was particularly helpful for this part of the interpretation, for example, the application of Critical Tribal Theory (Brayboy, 2005; Bryan McKinley Jones Brayboy, 2021; McKinley, 2018) enabled issues of colonial oppression and control through Tribal Self-Governance. The negative case analysis was performed to refine the framework based on cases that did not fit, or wholly fit, the confirmed patterns. The refined framework benefitted from this explicit step in the interpretive analysis.

This methodological approach has allowed for a systematic, transparent, and culturally-resonant analysis of the data, leading to a refined and validated Framework of Critical Success Factors for Tribal Self-Governance. As the following sections will show, the use of the NCFAM has facilitated both case-based and theme-based analysis, enabling a comprehensive understanding of the factors contributing to successful Tribal Self-Governance in the U.S. context.

5.3. Results of Further Literature Review

I was able to find several new documents and reports, including some published before 2017 that I had not reviewed previously, from this second stage review. As with Phase I, literature has been woven throughout Phase II the validation process. I also located evidence which either challenged individual factors, or added cautionary advice to factors, and the framework as a whole. The critical analysis of the factors against this evidence is included in the validation chapter.

The 2018 30 years of TSG (U.S. Senate, 2019), and the Senate Committee on Indian Affairs hearing celebrating the 30th anniversary of TSG (Senate Committee on Indian Affairs, 2018) also provided more evidence for the validation process.

Additionally, two more recent works proved to be valuable added literature when the U.S. Commission on Civil Rights released their 'Broken Promises' report at the end of 2018 (U.S. Commission on Civil Rights, 2018), detailing concerns about the chronic underfunding of Indian programs.

The second significant report was from the National Tribal Budget Workgroup also released an update of their analysis of the funding gap within the IHS, on 1 April 2020 (Inter-Tribal Council of Arizona, 2020).

Both of these significant reports have helped to solidify the presence of the "funding" factor in my framework. Additionally, the 'State of Indian Nations 2020' address by the NCAI President (National Congress of American Indian, 2020) included profound statements about where things are at today in Indian country. These more recent developments are included in this thesis to further validate what is important to effective TSG in health care. The findings of the second stage Literature Review have been categorized as the relevant success factor in my draft framework to supplement results of the participant interviews.

5.3.1. Brief Analysis of Successful TSG Organizations

Part of the literature which I was able to access concerned three of the top performing TSG in health care organizations: Southcentral Foundation (Alaska); Chickasaw Nation Medical System (Oklahoma); Jamestown S'Klallam Tribe (Washington). A brief description focussing on their Self-Governance profile is given below.

5.3.1.1. Southcentral Foundation (Alaska)

Southcentral Foundation (SCF) is a pioneer in Tribal Self-Governance in health care (Southcentral Foundation, nd). It was established in 1982 under Tribal authority of Cook Inlet Region, Inc. It began self-determination contracts in 1984 for specific health services. In 1998, SCF took ownership and management of primary care and other programs at the Anchorage Native Primary Care Center. SCF launched the Nuka System of Care in 1999, a customer-owned and customer-driven health care system. SCF serves over 65,000 Alaska Native and American Indian people, with significant improvements in health outcomes since implementing Self-Governance. The organization is led by Alaska Native people, with a board of directors comprised entirely of customer-owners.

5.3.1.2. Chickasaw Nation Medical System (Oklahoma)

In 1994, the Chickasaw Nation became one of the first Tribes to compact with the Indian Health Service to assume administration of health care services. This compact marked a major step in reasserting sovereignty and enhancing Self-Governance capabilities. The Tribe has invested heavily in health care infrastructure, including the construction of the Chickasaw Nation Medical Center and multiple clinics (Chicasaw Nation, 2024). The Chickasaw Nation Department of Health (CNDH) provides a wide range of services including medical care, dentistry, nutrition, mental health, and family services. The Tribe has developed innovative approaches to health care delivery, including virtual medical visits and mobile health apps.

5.3.1.3. Jamestown S'Klallam Tribe (Washington)

The Tribe was one of the first seven Tribes in the nation to participate in the Self-Governance demonstration project authorized by Congress in 1988 (Jamestown S'Klallam Tribe, 2024). In 1994, the Tribe extended Self-Governance to include programs and services provided by the Indian Health Service. The Jamestown S'Klallam Tribe operates the Jamestown Family Health

Center, which serves both Tribal members and non-Tribal community members. Self-Governance has allowed the Tribe to redesign programs and funding to meet the specific needs and priorities of their community. The Tribe has used Self-Governance to support various programs including education, housing, cultural enhancement, natural resources management, and business development. The Jamestown S'Klallam Tribe has emerged as a national leader in successfully implementing and promoting Self-Governance.

All three organizations demonstrate how Tribal Self-Governance in health care can lead to improved services, better health outcomes, and stronger Tribal sovereignty. They have used Self-Governance to tailor their health care systems to the specific needs of their communities, integrating cultural values and practices into their care models. Their developments have made significant contributions to employment and therefore the wider economy in their respective areas.

An analysis of documentation concerning these three organizations allowed the identification of up to 15 performance measures for Self-Governance. I compared these measures to the CSF Framework within the NCFAM analytical matrix.

In the following table I have compared the fifteen performance measures against the nine CSFs. The green cells represent agreement between the criteria. The red cells represent performance measures which do not map. Visually it can be seen that only two of the measures do not map, and the reason they do not map is that both of the measures relate to outcomes: economic development and environmental stewardship. These measures reflect the broader vision of the three organizations outside of the health care sphere. One of the measures relates to health care as an outcome and maps to ALL of the nine measures.

Table 1: Tribal Self-Governance Organizations and CSFs

Organizations operating Tribal Self-Governance in Health care	Critical Success Factor #								
Southcentral Foundation (Alaska); Chickasaw Nation Medical System (Oklahoma); Jamestown S'Klallam Tribe (Washington);	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1. Effective Leadership: Strong, visionary leaders who are trusted by the community and have a deep understanding of cultural values.	■								
2. Cultural Preservation: Commitment to preserving traditional customs, language, and values, integrating them into governance practices.		■							
3. Community Engagement: Inclusive decision-making processes that involve community members, ensuring everyone has a voice.						■		■	
4. Accountability and Transparency: Open communication about government actions, financial matters, and decision-making processes to build trust.						■			
5. Sovereignty and Self-Determination: Assertion of Tribal sovereignty and the ability to make decisions free from external interference.	■								
6. Rule of Law: Clear and consistent legal frameworks that support justice, stability, and the protection of individual rights.			■						
7. Economic Development: Creation of sustainable economic opportunities for the community, leveraging resources and partnerships.									
8. Effective Administration: Skilled and professional management of Tribal government operations, including the efficient delivery of services.				■					
9. Education and Capacity Building: Investing in education and training to build capacity within the community, ensuring the next generation of capable leaders.				■					
10. Intergovernmental Relationships: Building cooperative relationships with federal, state, and local governments while protecting Tribal autonomy.							■		
11. Adaptability and Resilience: Ability to adapt to changing circumstances and challenges while staying true to cultural principles.		■							
12. Infrastructure Development: Building and maintaining necessary infrastructure, such as health care, education, and housing facilities, to improve quality of life.									■
13. Health and Well-Being: Ensuring access to quality health care and promoting mental, physical, and social well-being within the community.	■	■	■	■	■	■	■	■	■
14. Environmental Stewardship: Responsible management of natural resources to ensure sustainability for future generations.									
15. Conflict Resolution Mechanisms: Culturally appropriate processes to resolve disputes and maintain harmony within the community.	■								

5.3.2. Further observations

After completing Phase I and progressing with the validation process, I continued to seek opportunities to conduct study tours to the U.S. to continue observing progress. These visits

continued after those listed at Appendix D but were constrained by the Covid outbreak between 2020 and 2022. My additional observations included:

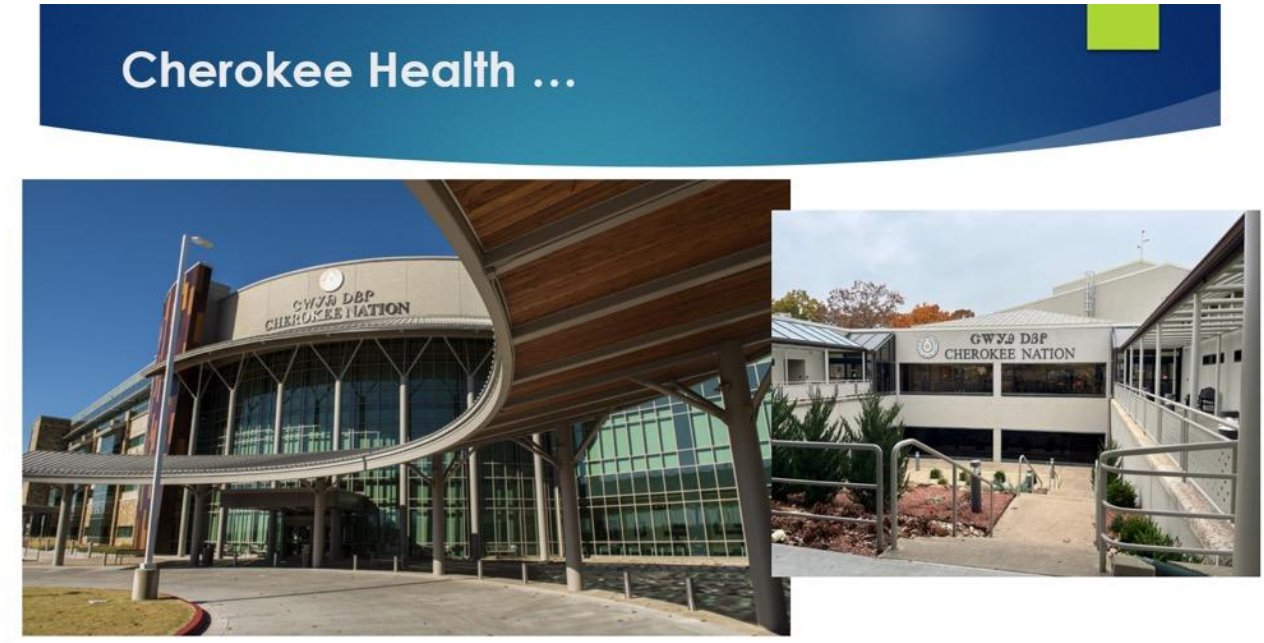
- **June 2018**: Site visit to Hawai'i Native Hawaiian health sites followed by Cleveland Clinic, Ohio where we looked at their Global Executive Leadership program and their Diversity and Equity program. I then travelled to the Global Health Innovation Center in Cleveland to look at technological advances; the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) to study collective impact in action; and the Cleveland Leadership Center. While these site visits were not specific to AI/AN health development, they did offer broader learnings that would contribute to effective Indigenous leadership and governance of health care. The primary learnings related to leadership development (workforce); use of technology and data; and working in partnership to achieve health outcomes (Kahui Tautoko Consulting Ltd, 2018). After Cleveland we travelled to spend time with the United South and Eastern Tribes (USET) organization in Nashville. There we heard about USET's 55-member Board (2 per member) and its use of "assertive aggressive diplomacy" when dealing with Federal and State governments. USET leaders were also highly committed to ensuring Tribal Nations were recognized as having the same sovereignty as the Federal Government and operating a government-to- government relationship, referring to it as "being a State within a State". They demonstrated alignment with my CSF framework on several fronts: Tribal unity; Political will; the importance of having a shared vision; importance of partnering / collaborating; strong leadership and workforce; and advocacy for financial flexibility and sustainability.
- **October 2019**: Site visit to Navajo Nation, Window Rock, Arizona and including visit with President, Vice-President, Chinle Health Center staff (largest of 12 health centers on the reservation) and Tuba City Health Care Corporation. Again, I observed strong Indigenous leadership; a highly organized political structure; importance of hiring and maintaining

strong health leaders; embedding of Navajo culture and language into health care; and Tribal unity and identity (Kahui Tautoko Consulting Ltd, 2019).

- **November 2023**: Site visit to Oklahoma to learn from the Choctaw, Chickasaw and Cherokee Tribes, followed by attendance at the 80th NCAI conference in New Orleans. The three Nations visited in Oklahoma offered an opportunity to view the 'pinnacle' of Indigenous Self-Governance in health care, where three Nations – through their economic strength – were able to reinvest in their own health system(s) to supplement the IHS funding they receive (Kahui Tautoko Consulting Ltd, 2023).

The health facilities of all three Tribes were of the highest quality I had ever seen. The health leadership were excellent, knowledgeable, and passionate about their work. The loyalty to Tribal leadership was evident throughout the visits and demonstrated the benefit of stable leadership, a strong workforce, and the strategic use of funding options to bring about the kind of care that the Tribes wanted for their own people.

Figure 12: Cherokee Nation Outpatient Health Centre



Note. Image source: Photo by Mara Andrews

5.3.3. Member Validation

The trustworthiness of results is the bedrock of high-quality qualitative research (Birt et al., 2016). Member checking, also known as participant or respondent validation, is a technique for exploring the credibility of results. The practice includes activities that allow stakeholders or case study members to verify and possibly influence case descriptions or interpretations. This method was entirely appropriate for me to validate my assumptions about the CSFs for TSG, and to ensure that what I had learned, read, and observed, was in fact correct.

(Birt et al., 2016) confirmed that from a practical viewpoint, member validation is justified by the common-sense wisdom of asking the source of information to verify that it is exact and complete. The authors further state that in positivist qualitative research, member validation basically serves the purpose of verifying factual information and assuring that the researcher's understanding of the studied phenomenon as presented in the case report or similar account is correct, in an objective sense, to increase validity. There are risks in this approach however, as some researchers can be tempted to select only the validations which suit and validate their research. When study results have been synthesized, the initial views of individual members are no longer there. Thus, to facilitate member validation the researcher may feel forced to present the findings too close to the initial data.

Also, one may suspect that project members, when reading the interview transcripts or case description may want to justify their actions, thus threatening the integrity of the initial data collection. (Evans, 2019) adds in response to a student question on a learner site, that Member checking is indeed:

> *a powerful tool in promoting the trustworthiness of your study, but it needs to be done the right way. Asking participants to comment on your interpretations to get agreement is not the purpose of this practice. Instead, asking participants to comment on your*

interpretations allows them to make sure that what you've abstracted through your analysis is faithful to what they believe.

While member feedback has validated my framework, to further affirm the validity of my findings, I plan to share my final draft of the conclusions of this thesis (before examination) with each of the members I have selected for the validation process. If any wish to view the entire draft thesis it will be provided to them, however I feel their review of the summary only respects their time and availability. Since there are a significant number of references to U.S. legislation in this thesis, I have sought approval from the Attorney that I interviewed to seek his help in ensuring accuracy of the U.S. legal references.

The feedback and comments of the participants will be included in the final version as I fully respect and trust their opinions, and I want to be respectful of the status of Native American and Alaska Native sovereignty and their journey of Self-Governance work.

The most important part of my research was to validate my CSF framework with the people who helped me create it. To conduct this phase of my research, I selected a variety of leaders who were interviewed in the years 2019-2020. I deliberately sought participants from the Federal government (Indian Health Service) and Tribal members at an individual, regional, and national Tribal level. I also interviewed an Attorney who works with several Tribes, mainly because that individual had significant experience and had also published many articles on the subject of TSG. The participants are leaders in their fields and well known among the many stakeholders in the TSG environment in the U.S.

I had agreed to interview the most senior person in the IHS and a senior executive who had extensive experience with IHS and the TSG agenda. I felt that inviting regional area IHS Managers would steer the study towards IHS direct service delivery when I wanted to focus in the self-governed service delivery sector. For this same reason I did not include anyone from the Urban

Indian health systems as they are not defined as 'self-governing.' I recognize that the small number of Federal employees makes their information and identity more identifiable in the study, but I also believe that nothing said by the Federal participants was either controversial or insensitive to the needs and aspirations of Self-Governing. In fact, both participants are strong and vocal advocates and supporters of the Self-Governance agenda.

I reached out to my selection of participants to brief them on my project and to seek their consent to participate in this research (see 9.3). I took a strengths-based approach and excluded Tribal representatives who had not chosen the path of Self-Governance. My focus is on what makes TSG work and what is critical to that result. During the course of my research comments often emerged about why some Tribes did not choose Self-Governance over direct service. Where appropriate however, I have captured these comments.

My target participants were people I had developed relationships with over the years, and as a result all of them agreed to my request to participate and none of them were concerned about my intentions. This is where the principle of whanaungatanga truly demonstrated its value and validity. Most of my invitees were very interested in seeing the results of this work as they had not had someone from outside the U.S. assess the TSG model and identify what made it work from an outsider's perspective. As one of my interviewees said, "we're in it, every day – it will be good to see the perspective of someone who is looking from the outside." While another said, "I can't wait to see what you come up with – I think it will be helpful for us moving forward to look at where we've been." Tribal leaders are particularly interested as they have their eye on transitioning TSG arrangements to other Federal agencies such as the Department of Justice and the Department of Transport and feel that the findings may provide additional impetus for their advocacy work in this regard.

My interviewees have all given informed consent for use of their names and titles however, the consent form confirms that if I wish to use a specific quote with their name, I will seek their

prior consent first. I provided an Information Sheet, a list of my general questions and the Consent Form (Appendix E). All participants provided permission for me to record interviews if I needed so that I could transcribe the interviews. I set up face to face interviews with each of the participants which reflects the kanohi kitea (face to face) principle described earlier in my methodology. Times and places were generally the choice of the interviewee to fit within their schedules. The schedule of participants is as follows next.

5.4. Research Participants

Table 2: Table of Participants 2019-2020

ROLE IN THE INDIAN HEALTH 'SYSTEM'	ORGANIZATION / GROUP	PARTICIPANT
Federal Government	Department of Health and Human Services (DHHS).	Director of Indian Health Service: RADM Michael Weahkee, Rockville Washington D.C.
		Deputy Director of Indian Health Service (IHS): Manager of Office of Tribal Self-Governance (OTSG) Ben Smith.
National Tribal Organizations	National Indian Health Board (NIHB).	Executive Director Stacy Bohlen (supported by Policy Analyst Robert Foley).
	Self-Governance Communications and Education Tribal Consortium (SGCETC).	Executive Director Jay Spaan.
Tribal Leaders	Tribal Self-Governance Advisory Group or TSGAG (to IHS).	Chair Chief Lyn Malerba (also Chief of Mohegan Tribe which is self-governing).
	United South and Eastern Tribes (collective of 27 Tribes on East Coast, U.S.)	Executive Director Kitcki Carroll.
	Alaska Native Tribal Health Consortium (represents 225 Tribes in Alaska).	VP Inter-Governmental Affairs Jim Roberts.

ROLE IN THE INDIAN HEALTH 'SYSTEM'	ORGANIZATION / GROUP	PARTICIPANT
	Jamestown-S'Klallam Tribe, Washington State.	*President Ron Allen (also sits on national TSGAG). Intended to interview but he made a written and oral statement to Senate Hearing in 2018 that I have used which covers his perspectives on TSG.*
Agents for Tribes	Hobbs, Strauss, Dean & Walker (2020), Portland – law firm working in Indian Affairs for 30+ years.	Geoffrey Strommer (Self-Governance expert), Lawyer.
	Sitnasuak Health Solutions, Alaska.	Carolyn Crowder, Director and Consultant to SG Tribes (especially in data, technology, and policy analysis).

The inclusion of Tribal leaders who sit at national-level tables, committees, and Advisory Groups and who regularly present to Congressional and Senate Committees to advocate for their interests, was intentional. I will provide the findings of my research to each of them as a sign of respect and reciprocity for the wealth of knowledge that they have given me.

According to Kovach (2010), using a conversational method in Indigenous research differs from its use in Western research in several ways: a connection to Indigenous knowledge, a location within an Indigenous paradigm, a relational nature, and a purpose (which is often decolonizing), following a specific protocol that reflects the Indigenous knowledge, a flexible nature, collaboration, and reflexivity (Dennis, 2014; Kovach, 2010). Dennis (2014) also utilized a conversational method and noted one benefit as greater control of disclosure for participants, which is consistent with cultural norms (Dennis, 2014, pp. 32-47). Bessarab and Ng'andu (2010) affirm that yarning (common word of Aboriginal population of Australia for story telling) is relevant in Indigenous research.

In her article on the Pūrākāu method, Lee (2009) describes this as a 'traditional form of Māori narrative' and affirms that storytelling has always been one of the key methods that knowledge was sustained and protected within Indigenous communities. Lee (2009) further states that reclaiming storytelling and retelling our traditional stories is to engage in one form of decolonization. In their review of storytelling within research in public health, McCall et al. (2019) identified that the process of storytelling has multiple research aims. Included in these aims is its ability to inform the researcher through extraction of information, but also as an intervention to facilitate a process of 'reflection and reworking of experience and knowledge in the research participant.' As one author within the McCall study identified "essential to storytelling is that it seeks to convey an experience in such a way that it seems real" (G. Mead, 2014). Certainly, I found during my conversational interviews, that participants often reflected on their own experiences thoughtfully as many had never been asked about what range of specific dynamics make TSG work. Most just knew it was the right thing for their Tribe(s) and that Indigenous people had fought for greater control of their own affairs for many decades. Having to specifically identify specific drivers outside of the cultural, moral, and historical imperative, was actually quite thought-provoking for some.

Using my interview questions as prompts, allowing participants to tell stories in their own words and in their own time, provided a meaningful and rich basis for collecting information in the way that was founded on our prior relationship built on trust and respect. My approach to these interviews was really to make them dialogues – that is certainly the approach I have taken in the past 20 years to build relationships. I asked participants first to tell me what they thought were critical factors for the success of TSG, without showing them my framework. I did not want to bias their thinking. I used conversational interview techniques to let each person speak and explored specific issues as they arose to understand them better. Once they had exhausted their ideas and

perspectives, I then shared my framework and asked for their thoughts on the overall model, and then on each specific factor.

5.4.1. Analysis

Recordings from interviews were transcribed verbatim using a software program and edited, then saved under the interviewee name and date in the same folder as the copy of their signed consent form. I used a deductive approach to thematically analyze the participant's responses in each interview against my pre-conceived CSFs, as opposed to an inductive approach which involves allowing the data to determine the themes as used to develop the draft framework. Since my questions and their responses were focused on TSG and the elements of my draft framework, this method was the most obvious.

For all interviewees, I did not identify any information that they shared which could not be coded to one of the CSFs - or was not related to their perspective on the overall framework. All of the issues and ideas that my interviewees offered could be affiliated to one or more of my nine factors.

After coding all of the interview notes, I then copied the relevant sections from each transcription into a single document for each CSF, so that I could undertake thematic analysis for each CSF. High priority CSFs were determined by interviewee feedback, and often this was enhanced by these higher priority CSFs generating a greater volume of comment than others from interviewees, or from being top of mind as they initiated their responses to my questions.

Even though my participants are identified, I wanted to keep their individual and collective responses for each factor anonymous so that specific comments could not be attached to individual participants. I felt it was important that each is recognized for their enormous contribution to TSG and therefore to this research, but also that their free and frank comments be honored by keeping them at least somewhat unidentifiable. In truth – each of the participants knows each other very

well, so it is likely they will all know who said what in any case. This is not to say any comment was contentious or insensitive.

This thesis identifies the subjects by letter and number such as a Federal interviewee or a Tribal representative or agent interviewee. Where validation members commented on specific factors or issues, I attached their views to that factor in a verbatim manner. I was conscious of not over-analyzing or diluting what my member participants shared and aimed to keep their rich commentary as authentic and real as possible.

5.4.2. Perspectives on the Overall CSF Framework

As part of my validation process, and typically towards the end of each interview, I shared my puzzle diagram of the nine critical success factors with several of my key informants and asked whether they thought this was a reasonable representation of CSFs for TSG, or if anything was missing. Overall, I received positive feedback about the nine factors, but additional comments related to the relative importance of certain factors from different interviewees. Several Tribal participants affirmed:

> *"I don't think there's anything that doesn't belong. I do believe though - you don't need all the pieces perfect in order to make this happen… Yeah. I really have to commend you. You came up with really nine things that are really important to focus on. I have to say, you've done a really excellent job with that" [Tribal participant 1]*

> *"I think you've done a remarkable job of the dimensions…but I think you hit on the two or three most important elements. I will talk about policy and political will… I think it goes without question that this is an acknowledgement of policy nationally amongst our national Tribal leaders. And the importance of staying unified" [Tribal participant 3].*

"Let's see, I think that you've pretty much captured it all. All nine of them are important for overall success and they're all going to be involved at different stages, but some of them might rise up to a higher level depending on the external environment at that time" [Tribal Participant 4]

5.4.3. Perspectives on Implications for New Zealand

Interviewees were asked if they were to give advice to Tribal leaders in New Zealand on considering a pathway of TSG arrangements, what would they say? One Tribal participant identified that for Tribal leaders, it was important to create protocols for holding their relationships together and maintaining Tribal unity advising that:

"I think having really well-written resolutions or some kind of agreements on how you're going to interrelate with each other, what the authorities are, how you're going to communicate and how you're going to resolve differences, having all those things written down for people to understand… It's almost like a diplomatic memorandum of understanding or agreement that you have with each other".

Another Tribal participant advised that Tribes should strategize a staged approach based on Tribal priorities, advising that:

"I think whether it's health care education or anything, I do think unless they're happy having the Federal government run that program for them, and the government is getting the results they want for their Tribal communities, then they really should be looking at ways to strategize to take that over. Create a process….it took years to unfold in the United States…and then eventually expand it".

One of the other Tribal participants stated that they would advise Tribal leaders in New Zealand to focus on controlling budgetary processes aligned to Self-Governance stating*:*

"… make sure your Federal partners are advocating for the true need, not for what the administration says they should ask for".

One Tribal interviewee also offered a comment about the advice that they would give to the New Zealand Government on this same issue stating:

"… if you're dissatisfied with your past policies or failures of Māori policy, then you should be looking for alternatives. And self-determination is one that has buy-in from both the Indigenous people, but it also should have buy-in from the leadership of the colonialist governments".

5.5. Findings from the validation process for specific factors

5.5.1. Policy and Political Will

Having the right policy and legislation in place, along with the will of political advocates to oversee the implementation of those policies, is an essential component of TSG.

5.5.1.1. The need for political will by both Tribes and Government and associated legislation

As of 2018 (United States Senate, 2018), over 50 percent of all Federal Indian programs were being carried out by approximately 360 (63%) of the then 573 federally recognized Indian Tribes. This would not have been possible without some level of political will from both Congress and the Tribes to give effect to the policy of TSG expected under ISDEAA. Where the political will does not exist, either to enforce the policy or to resist policy, this can present significant barriers to Tribes and their aspirations for Self-Governance. There has been a great deal of evidence showing that, despite ISDEAA policy, Federal agencies at an operational level have strongly resisted handing over further programming and resources to Tribes.

From the key informant interviews, several Tribal members consider political will as very important with two participants stating that:

"… but you need the political will, not just of the Tribal leaders, but to have all these allies on the hill [referring to Capitol Hill]".

"The most important piece that jumped out at me …was what you've currently labelled the policy and political will … it's presidential Congress, White House support. But I think it took the failures of the United States to finally get to acknowledge that its past policies did not work … the policies of self-determination have been the most successful policy in all of the United States."

5.5.1.2. Political will that led to TSG policy and success

The Self-Governance Communication and Education Tribal Consortium (SGCETC) appeared at an April 2018 Senate hearing convened to reflect on the 30-year anniversary of TSG. They reminded Congress that ISDEAA was enacted with three primary goals:

- to place the Federal government's Indian programs firmly in the hands of the local Indian people being served
- to enhance and empower local Tribal governments and their governmental institutions and,
- to correspondingly reduce the Federal bureaucracy.

The SGCETC describes the many benefits of TSG in their submission including increased efficiency i.e., Tribes are closer to the community than Washington DC decision-makers and are able therefore to respond to needs and concerns of citizens much faster and more efficiently. Tribal planning and management capabilities are strengthened through more rapid access to information, and the growing number of qualified members with management expertise. The SGCETC noted that Self-Governance affirms sovereignty and that through signed compacts, Self-Governance affirms the fundamental government-to-government relationship between Indian Tribes and the

U.S. Government. It also advances the political agenda of both the Congress and the Administration, to shift Federal functions to local Tribal governmental control.

> *"TSG has been successful and is demonstrated through … some of the most innovative and creative governments because of their experience operating successful Self-Governance programs. Under Self-Governance, Tribal capacity expands, knowledge and recognition of local issues increases, and greater community engagement results. Self-Governance encourages Tribal governments to exercise greater control over their planning and budgeting processes to meet local needs. Often too, Tribal citizens become more involved in the governing process and the identification of local needs and accountability of Tribal governments improves." [SGCETC Submission to 2018 Senate Committee on Indian Affairs hearing, p.1]*

Further, Strommer and Osborne long-standing lawyers for many Tribes, also assert that TSG works because:

> *"it sees the further the movement away from pervasive Federal control and towards Tribal autonomy. It brings jobs to Tribal communities and builds Tribal administrative capacity, but Tribes also exercise self-determination through economic development, cultural activity, language revitalization, and other aspects of nation-building" (G. D. Strommer & S. D. Osborne, 2014, p.76).*

(Johnson & Hamilton, 1994) note that the passing of the Tribal Self-Governance Act identified a fundamental shift in the relationship between the Federal government and American Indians' stating that:

> *"this law is an evolutionary response to the historic tension between the two main tenets of Federal Indian law – Tribal Sovereignty and Federal Trust responsibility. The law was a*

> *very bold and deliberate step in the direction of empowerment and away from paternalism replacing a stifling Federal bureaucracy with Tribal governments focused on choices and responsibility." (Johnson and Hamilton (1994, p.1251)*

Johnson and Hamilton define this evolution as moving from 'Federalization' to 'Tribalization'.

At a Senate hearing in May (2008) Chairman Ron Allen of the Jamestown S'Klallam Tribe in Washington State gave testimony on the subject of TSG (Allen, 2008). Chairman Allen is a Tribal leader whose Tribe was one of the original 10 Tribes of the demonstration pilot for Self-Governance in 1988, and one of the first seven Tribes that advanced to Self-Governance in 1991. In 2008, his Tribe was celebrating their 20th anniversary of the Self-Governance movement. He stated that:

> *"what Self-Governance is, in a nutshell, it is empowering the Tribe. It is recognizing our sovereignty as a government and recognizing our rightful place as a government within the family of the American political system … we need to be empowered to take control over our own affairs and manage our own affairs and not to be second guessed by a Federal bureaucratic system." (Allen, 2008, p.4)*

Chairman Allen also described the impact of changes in the policy and strengthening of Tribal control stating that:

> *"we were contractors back in the 1970s and 1980s and into the 1990s. In the 1990s, when Self-Governance emerged, now we asked the Federal Government start recognizing the Tribes as governments, let us make our own decisions as governments, regarding the limited resources that the Federal Government provides to our people for programs A through Z. It has been a remarkable success." (Allen, 2008, p.5)*

Chairman Allen listed indicators of success of Self-Governance as promoting efficiency, strengthening Tribal planning and management capacities; providing flexibility to tailor programs to needs, more nimbly than the Federal government can: and affirming sovereignty. It also advances the political agenda of both the Congress and the Administration: namely, shifting Federal functions to local governmental control.

Chairman Allen identified that as a long-term Self-Governance Tribal leader he has had the opportunity to talk regularly with many other Tribal leaders regarding Self-Governance. Although they recognize the implementation problems, he states that:

> *"every single Tribal leader made a point of praising the overwhelming success of Self-Governance." (Allen, 2008, p.5)*

A Tribal leader from the Hoopa Tribe, also provided his statement to a 2012 Senate hearing in support of the TSG program stating that:

> *"Through Self-Governance, Indian Country has experienced many dynamic and pioneering changes in the last few decades. Through Self-Governance, Tribes have been able to strengthen Tribal government, stabilize funding bases, improve and expand services and increase staffing and technical capabilities. For this reason, they work."* (Advancing the federal–tribal relationship through self–governance and self–determination, 2012*, p.42)*

One of my Tribal participants described that in some areas, Tribal governance of health services had become an attractive option for non-Tribal patients.

> *"One thing that is also interesting with kind of looking now at Self-Governance and lot of those Tribes that were the early adopters, is that you see … a lot of that mix between Tribal citizens and non-Tribal citizens … and it's really been amazing, not just for health*

care, but also on other social services sides that whenever Tribes have taken over through Self-Governance, a lot of them have been able to be so innovative and developed such strong systems that you actually have non-Tribal citizens wanting and using it."

5.5.1.3. Reluctance of agencies to fully embrace Tribal Self Governance

The evidence I gathered both from literature and key informant interviews, revealed a pattern by various Federal administrations not to fully implement ISDEAA and TSG, and this reluctance has slowed TSG progress and Tribal assumption of control of their own affairs, despite their recognition as sovereign Nations. This is why political will is such a critical factor in the success of TSG – without it, progress is slow or non-existent and highly frustrating for Tribal leadership. One Tribal participant affirmed that even with political will, there are still barriers presented by Federal agencies in implementing Government policy stating:

"be wary that even when you have political will and you have your parliamentary leaders on side, when it goes down the chain into the agencies, it's the bureaucrats who then become your biggest barrier because they don't want to let go of the power. It's what I call bureaucratic entrenchment. And many of these people are Indian people too. They're our own people. And they fight you because they realize that if a Tribe takes over management of the operation that potentially they're out of a job"

Another Tribal participant agreed that appropriate policy is vital to Self-Governance, and that it was important to continually review and update that policy to keep pace with change, stating:

"For me Tribal self-determination has become the most successful bipartisan Indian policy ever enacted by Congress. This transfer of responsibility has done a lot to empower Tribes to promote Tribal economies, build governmental infrastructures, provide law and

order, manage Tribal natural and cultural resources, meet the health care and educational needs of their members, and perform other essential governmental functions".

There have been many other commentators raising concerns about the reluctance and resistance of Federal agencies to fully implement ISDEAA at an operational level. Several leaders made submissions to the Senate Committee on Indian Affairs in 2018 for the 30th anniversary celebration of the ISDEAA legislation. One in particular (Senator Tom Udall) lent his support to Tribal Self-Governance with comments such as:

"*…the reality is the road to the full exercise of Tribal self-determination in the 1970s, and now of Tribal Self-Governance, has not been swift or without detours … despite all the gains that have been made over the past three decades, Self-Governance Tribes continue to confront new challenges to old problems, problems such as agency inertia and historical resistance to expansion of the program and inequitable access to BIA funds for new programs*". (United States Senate, 2018, p.1)

Tribal interviewees in my study agreed that there has been resistance from Federal agencies within DHHS to expand the Self-Governance program beyond IHS, and educating agencies was important to advance the TSG cause. Both interviewees offered comments such as:

"HHS are completely resistant. And there's been efforts since 2003 for us to expand Self-Governance into some of those other non-IHS agencies that are still under the HHS setting. I think that our biggest roadblock is just the Federal bureaucracy. And they're completely resistant to change. There's a very paternalistic type of belief that there's no way Tribes could do this. And yeah, it's quite a problem."

"I think that what we're finding is that we're really good throughout Indian country in communicating with Congress …. And we're really good about communicating within IHS and within BIA … but we're not so good about moving to other agencies".

Strommer and Osborne note that self-government is "*essential if Tribal communities are to continue to protect their unique cultures and identities*." However, they identify several obstacles to TSG: outmoded bureaucratic processes; lack of Federal agency coordination, and regulations and laws that prevent Tribal governments from equitable access to Federal programs on par with state and local governments (G. D. Strommer & S. D. Osborne, 2014, p.76).

Kevin Washburn of the Minnesota Law School raised concerns that the Federal government's slow-down in expanding new TSG arrangements across other agencies beyond the BIA and IHS, confirmed they were not committed to TSG (Washburn, 2005).

5.5.1.4. Tribe's use of political will to choose not to enter into Self-Governance arrangements

Bauman and co-authors point out that there are reasons that some Tribes might choose to contract rather than seek a compact (Bauman, 1999). To receive a Title I contract, the Tribe does not need any prior experience in program management, while evidence of management experience is required for a Title V compact. Self-Governance compacts offer more flexibility in using funds and re-designing programs and, since compacting is not subject to regulation, the terms are more flexible and subject to negotiation.

Kalt and co-authors (Kalt et al., 2003, p.36) note in their research that that the "*so-called "nation building" approach holds the keys to self-determined social, political, and economic development for Indigenous communities*." Their study focused on why some Native nations took effective control of their futures - while others did not. Some wanted to break away from established patterns of poverty and powerlessness, while others wanted to regain control of their own affairs and build societies that worked. They also wanted to launch new initiatives, and to

reorganize their relationship with Federal governments to develop creative new strategies for addressing burdensome social problems. Cornell and Kalt (Cornell & Kalt, 1998) note many success stories in these pursuits. However, they also note that in the same period many other Native nations either took no comparable action at all to restore effective Indigenous control of their societies, or initiated actions.

One Tribal participant held a view on why Tribes may choose not to enter into Self-Governance arrangements:

> *"I think that definitely the funding issue and economics associated with it is massive. And particularly whenever you're looking at smaller Tribes that . . . there's just no way that they would be able to take over and provide the level of service that the Federal government can provide, simply because of the economies of scale. It's just not there"*

This same participant also noted that in some parts of the U.S., there are issues where the IHS is the largest employer.

> *"So, a lot of their Tribal citizens actually will work for IHS, and they get Federal benefits, they get pension, they're pretty happy with what they receive from that. They're on the government scale for pay, so they get regular pay raises. And it's kind of scary, I think, for them to think of going from that system to a Tribal system that they don't know what it's going to look like yet."*

5.5.1.5. Barriers to Expansion of Tribal Self-Governance of DHHS Non-IHS Programs

Within the DHHS, TSG has been limited to IHS programs. The DHHS has many other programs that could or should be considered for Tribal compacting such as the Substance Abuse and Mental Health Services Administration (SAMHSA) – an area of particular interest to Tribes because of the many health problems evident in this area for Tribes. In 2001, the Office of the

Assistant Secretary for Planning and Evaluation conducted the Tribal Self-Governance Demonstration Feasibility Study. The Draft Report on the Study (U.S. Department of Health and Human Services, 2003), identified 11 DHHS programs as "feasible for inclusion in a Tribal Self-Governance demonstration project" (p. 15). To date none of the other DHHS programs have been included as eligible for Title V compacting with Tribes despite years of lobbying for this to happen. A Federal participant confirmed that:

> *"The long-term goal is to expand Self-Governance beyond DHHS, beyond the Department of Interior to other parts of Government. Department of Justice. Education."*

5.5.1.6. Political will of the current Government

An analysis conducted on the Trump Administration's budget blueprint and its potential impact of self-governing Tribes was undertaken by Lexology who provide legal updates, analysis and insights on international matters (Kilpatrick Townsend & Stockton LLP, 2017). Their perspective was that Tribes should be concerned that Federal programs benefiting Tribal communities might become the target of budget cuts under the Trump administration and the Republican Congress. They also stated that:

> *"with creative, strategic leadership from Tribes, Trump's administration could rally around a key Tribal priority: the pursuit of Self-Governance. By taking a pragmatic approach to Trump's regulatory reform agenda, laid out in recent executive order and his "America First, Budget Blueprint." (2018). Tribes may be able to achieve more to advance Self-Governance than they anticipate." (Kilpatrick Townsend & Stockton LLP, 2017)*

5.5.1.7. Critique of this factor

Some researchers (Cornell & Kalt, 2010; Deloria, 1983) highlight the risks of over-reliance on federal policies, which can perpetuate dependency and limit true self-determination. This challenges the framework's emphasis on policy and political will as a critical factor, suggesting that more emphasis should be placed on developing independent Tribal policies that reflect local needs and aspirations and alignment with Tribal sovereignty and self-determination

A study by Indigenous health researcher Dr Donald Warne and Cherokk and Lakota scholar Dr Linda Bane Frizzell (D. Warne & L. B. Frizzell, 2014) provides a comprehensive overview of the historical and contemporary issues in American Indian health policy. They argue that while policy is critical, it must be accompanied by genuine efforts to dismantle systemic barriers and empower Tribal governance. This suggests that the CSF should emphasize the role of Tribes in shaping policies that reflect their unique needs and priorities. The Affordable Care Act and IHCIA have provided new opportunities for Tribes to enhance health care delivery through increased funding and policy support. However, Warne and Frizzell note that these legislative changes alone are not sufficient to overcome the structural barriers faced by Tribal health systems. This insight challenges the CSF's reliance on policy and political will as a critical factor, suggesting that deeper systemic reforms are needed.

Cornell and Kalt's work suggests that policies should empower Tribes to govern themselves according to their cultural values and priorities (Cornell & Kalt, 2010). They highlight the critical role of sovereignty in enabling Tribes to make decisions that are in their best interests. This supports the CSF of "Policy and Political Will," suggesting that true Self-Governance requires both internal and external policies that respect and enhance Tribal sovereignty and in fact, the reliance on federal policies can be problematic if these policies do not support Tribal sovereignty and self-determination. Similarly Kukutai and Taylor's work suggests that policies should empower

Indigenous communities to govern their data, ensuring that it supports their governance and development goals (Kukutai & Taylor, 2016).

5.5.2. Unified Tribal leadership

There is no doubt that this factor is the one of the most significant of all in the CSF framework. Tribal unity around a shared vision was constantly discussed by all key informants whether they were Tribal or Federal government interviewees. It became evident after just a few interviews that this factor needed to be elevated to a stronger position in the framework. Essentially it was the *most* critical of all the critical success factors and that without it, TSG would be almost impossible. Key informants provided many examples of, and reasons for, this.

A Tribal participant explained that it was important from a self-determination lens, for Tribal leaders, individually or collectively, to be clear that they can opt in or out of a TSG journey. Having the choice is important to leaders not to enter into a Self-Governance agreement.

5.5.2.1. Active participation by Tribes in decision-making

Active participation by leadership is also essential. One Tribal interviewee provided an example of three Tribes who came together to pursue a self-governing arrangement, providing resolutions from their governance to confirm so. One of the Tribes, however, failed to send a representative to the meetings to participate in the planning and negotiations, rumors began flying about the reasons for this, and as a result the Tribe pulled their resolution. One Tribal participant said:

> *"You can't have Tribes provide authority without some kind of reinforcement that they will actively engage in that. You have to ensure that there is full participation and communication, because if you don't have that in place, you really don't have that unity that you're looking for."*

In another part of the U.S., the Alaska Native communities made decisions by consensus. Everyone may not agree but if the majority are ready to progress (with entering into TSG agreements), then other communities are asked to let the majority move forward. Two Tribal interviewees stated:

> *"We made it work. You can have consensus with some objectors, but if they're willing to step aside and let the majority rule for the greater good of all. It was hard. It took a long time. The real principle you're working towards is the greater good of all."*

> *"You need self-regulating, self-enforcing rules that you all agree on, on what you expect of each other in participation and communication and reporting, decision-making and things like that. I guess planning for any contingency on that would be a good thing."*

Much of the objection to moving into Self-Governance was identified as fear-based and a lack of confidence by citizens and leaders in the ability of the people to actually do the work and be successful. Two Tribal participants stated:

> *"You just have to work through those. The government is going to create a lot of fear in people. They'll say, 'you're going to lose this and you're going to lose that' and that comes from people thinking they are losing their jobs when Tribes take over."*

> *"'we're going to lose our hospital' or 'they're going to take the money and not spend it on health'. You really have to just expect that and plan for that."*

One Tribal participant also noted that coming together was about unifying a Tribal sovereign group:

> *"You have to respect that sovereignty no matter what. Because if you don't, if you lose that, you don't have the true sovereignty aspect of what you're trying to do. A unified*

Tribal system must be there to support everyone. You really have to factor in, how is this going to affect our weakest Tribe, or our smallest Tribe? When they make decisions".

It was identified that in the early stages of agreeing to enter into a Self-Governance compact in Alaska for instance that trusted fellow Tribal leaders was essential:

"the smaller Tribes that were worried that they were going to be gobbled up by the bigger Tribes and the bigger consortium. Now, if you go to our negotiations a lot of the smaller Tribes don't even show up because they know they're in good hands. They know that people are looking out for them."

It was further noted by this same interviewee that building trust and unity among Tribes is not easy.

"During times when we started fighting in caucus, it was always good to have that wisdom bearer role of someone, an elder who steps up and says "Hey, listen. We are getting off track"

"You always have to have people that are highly respected. In the western world they call them Sergeant at Arms. In our culture, it's our elders or people that are just respected in the community to get up and just tell us to get back on track."

A Tribal participant affirmed the concept of larger Tribes respecting the voice of smaller Tribes stating:

"I think it's our job to give voice to the smallest Tribes that maybe don't have the capacity to be at the table. So, I think we always need to be cognizant of the fact that we need to be respectful of everyone's needs whether they're a big Tribe or a small Tribe."

A Federal participant felt that the journey taken in Self-Governance has only happened because of Tribal advocacy and unity.

> *"They have worked together to get where we are today – they fought for the original legislation way before President Nixon made his ground-breaking Indian policy announcement and they've been working together ever since to implement that policy and the ISDEAA legislation that followed … they need to be congratulated for what they've achieved in the last 40 years. They're trying to undo the oppression of the last 200+ years of oppressive policies and have made huge strides."*

A Tribal participant agrees that Tribal unity is essential in the realm of Self-Governance stating that:

> *"I think it's important that it gets back to not letting the paternalistic government divide and conquer you. Hold your guns on your policy. How important is Tribal unity? I think it's very, very important. If you're coming to the dominant government with five different priorities, then you've already in some way achieved the objective that they're wanting to impose on you, which is to keep you divided and separate you."*

When asked what triggered Tribes to come together to push the Self-Governance agenda, a Tribal participant stated:

> *"I, for one, don't think the evolution of Federal Indian policy in the United States happened in a microcosm. It wasn't because of the devices of who we are as Indigenous people on our own. I think the movement of the civil rights era in the United States had a lot to do with serving as a catalyst for making it the right time . . . after the 1960s you had the civil rights era then after the Congress and the administration dealt with the civil rights there. I think the Tribal leadership were saying enough is enough."*

Another Tribal participant also noted that despite the new policy announced by Nixon in 1970, this did not prevent Federal agencies from resisting the policy using such mechanisms as defining many of their functions as inherently Federal and unable to be contracted out.

> *"So, from there, leaders again said, "Enough is enough on that," and their work from then was the path of self-determination and Self-Governance. I think Tribal leadership is always going to say, "Enough is enough." If we ever stop saying it, then I think we will not be doing justice for who we are as Indigenous people"*

A Federal interviewee also commented on unified Tribal leadership saying that:

> *"I think it's easier to build unity within a single Tribe, although some Tribal leaders will probably contest that, but it's definitely hard across 573 Tribes. And I think a lot of it, the root cause is because there's so many different factors that come into play of the haves and the have nots. Whether it's natural resources, whether it's language, whether it's culture, whether it's relationships with the state that are better than in other parts of the country."*

Another Federal participant also described how they rely on working in a unified way with Tribal leaders:

> *"I think that that comes back to the unified, not only Tribal leadership, but leadership within government as well and then that unified voice … appropriations are a good example where they want to know that my message internally is aligned with Tribal leadership, and we are all saying yes this will help save lives. I think that adds a lot of strength to your advocacy efficacy efforts to say, I have the Tribal leadership onside...they are in agreement with me about what we're talking about here."*

5.5.2.2. The vital role of communications and education for Tribes

One Tribal participant described the role of the SGCETC and that it is a consortium of Tribes aimed to supporting Tribal unity stating that the SGCETC is:

> *"to help keep that unity moving forward and . . . making sure that there's that community and that sense of feeling and that sense of we're all in this together and how can we move forward for the benefit of everyone instead of everyone looking out for themselves."*

This same participant also supported the formation of the SGCETC and identified potential issues if it did not exist.

> *"I think that without SGCETC or something similar to bring Tribes together, that you actually are giving the Federal government more power.…whereas a consortium and an organization like SGCETC brings the Tribes together so they share information, and they can identify where there's a couple of bad players in a Federal agency. But without that, then everybody does that kind of work in silos"*

A Tribal participant described that having a core group of self-governing Tribal leaders who are continually promoting TSG is essential to maintaining the focus on Self-Governance.

> *"I really think that having that core group of Tribal leaders that were such advocates and so supportive of Self-Governance …. a lot of them were Tribal leaders that have been around in their leadership positions for a long time. … they have a level of respect within Indian country that I think helps to form that coalition."*

5.5.2.3. Tribal advocacy promotes unity

One Federal interviewee described the strengths of Tribal leadership in advocacy.

"The national advocacy groups (NCAI, NIHB) are great for demonstrating magnitude at national level, but the individual Tribal leaders I think have greater access to Congressmen and Senators. If you are a Tribal leader of a sovereign Tribe, you would likely get an audience before one of the advocacy groups."

Another Tribal member agrees that the national advocacy groups are important for Tribes, primarily because they become the holders of knowledge over generations of leadership and personnel changes.

"I think the other piece that I would say is the importance of institutions . . . the Self-Governance advisory group, NCAI, Area Indian Health Boards and NIHB. Because there's so much, the process is very fluid. The leadership changes and unless you have institutions that can carry the continuity of the policy, then it's so easy for things to just go by the wayside. So there has to be a commitment or of institutions to support the mission and objectives of Tribal leadership in order to carry that water over and over again. Either across the generations, because who knows how long it's going to take across the different offices or the terms and limits of people that will be in place. Whether that be on the Tribal side or even in the government itself"

Another Tribal participant identified that as Tribal entities they have two roles: Program Work and Policy Work, and that it is all about meeting Trust and Treaty obligations, explaining that:

"We have aspirations to look beyond the BIA and health into housing, social services and transportation. We have a strong focus on Nation re-building, influencing health policy and this is an essential part of our role. We know there is some tension between wealthy Tribes and impoverished Tribes, so coming together ensures there is care taken for those

who may not have the resources of the larger Tribes … it is a symbiotic relationship. Working together we don't sabotage each other – we are more willing to work together".

One of the Federal interviewees also added that advocating for Tribes wishing to enter into Self-Governance, and existing self-governing Tribes, was an important function for the IHS.

"We need to see our role as Federal government officials as temporary custodians and our role is evolving. So, what may have been a 100% federally operated program is, over time, now for the IHS where it's a 60/40 margin. 60% Tribal, 40% Federal. But over time we'll have a residual function of contract oversight and some supportive functions that the Tribes feel need to be there.".

5.5.2.4. Educating Tribal leadership

One Tribal participant stated that informing and educating Tribal leadership was essential to supporting them to perform their leadership roles in their communities and at the political level in DC.

"We rely on technical advice of policy analysts, attorneys and the people who run our health care systems to ensure they are providing information to our leaders in a way they can understand it, speak to it and be credible."

One participant who has been working with Tribes for many years, provides advice on effective advocacy by Tribal leaders and how this can be optimized. He states that:

"More than any other group of Americans, Native Americans are affected by Federal action. Because of this, it is extremely important that Indian Country advocates have focused and effective strategies when working with the U.S. Congress and Federal departments and agencies."

One Tribal participant lists a number of important strategies for Tribal advocacy whether individually or collectively. I include it here as it provides a useful insight into the background that is done to support Tribal leaders to conduct effective advocacy:

- Strong relationships with politicians to undertake successful lobbying
- Having a thorough understanding of the issues that Tribes are discussing to gain credibility
- Be clear and specific on what is being asked for and offer solutions
- Distil key points to their essence as everybody is short on time
- Use real-life human stories that illustrate the points you are making.
- Understand the Congressman and their interests
- Have well-written briefing materials
- Do the work for the Congressional staff for instance, drafting letters for staff to use
- Put out press releases if you have good meetings with a politician
- Political contributions may be considered
- Build Alliances with other Indian Tribes and Tribal Organizations that share common interests
- Schedule meetings in advance
- Lobby at home not just in the capital city
- Look for opportunities to arrange site visits for Members of Congress and for their staff

5.5.2.5. The Importance of Tribal organization – locally, regionally and nationally

A Tribal participant confirmed the need for Tribal unity and some of the history that led to Self-Governance policy.

"So, you look at the National Congress of American Indians, they were organized in 1944. So, it wasn't all of a sudden somebody, a group of Tribal leaders got together in '44 and said, "Oh, here's our bylaws and charter." I'm sure it took them a long time to get to that point. Because when we're divided, we're not organized."

Another Tribal participant described the vital importance of the various organizations and forums for leaders to come together to strategize and make decisions, saying that:

"I think it's huge. The National Congress for American Indians has been around for a long time, right? But I do think there is such regionality, there's such regional differences that it's helpful to have the regions also have their own advocacy organizations like we do with NCAI. What happens in the east is very different than say what happens in the southwest"

5.5.2.6. Having a shared vision

Three Tribal participants consider Tribal unity very important in developing a common agenda of priorities and a shared vision with comments such as:

"... we do have Tribal Self-Governance who have their strategy session every year. Every year we get together and say, "Of all the issues, what are we strategically going to focus on, and who are we going to address this with?" We come up with a strategy and a plan for it that works with the State"

"Tribes have to get on the same page first to be able to do the advocacy to influence Federal government to change policy or change law and come up with something new ... we need to come together ... so that then you get to the political will of government"

"You have to be able to articulate your goals and to speak to each of those Tribes in a way that demonstrates that it is better to approach these issues together with a concerted voice than it is for each one of us to talk about the issues"

5.5.2.7. Self-governing Tribes and Direct Service Tribes

One issue impacting Tribal unity is the fact that Tribes are essentially categorized into two groups – those who are self-governing and those who are not and are still receiving health care services from the IHS (the direct service Tribes). This has caused some tension from time to time as two of the Tribal participants noted:

"There are times now with the direct service Tribes, some Tribes get nervous when Self-Governance is trying to advocate for something that they think somehow will diminish their funding or diminish their programs. Because it's two different systems now"

"They felt that those Tribes that wanted to go Self-Governance were just trying to take over all the funding, and there wouldn't be any funding left for direct service. And so, they were scared … they were heavily opposed to it and that unfortunately, even 30 years later, it's still that perception, it's still something we're battling to overcome"

5.5.2.8. Tribal and Urban Indian Health Programs

It was noted by one Tribal participant that there is at times tension between Tribes and Urban Health organizations.

"The other group that really gets left out though sometimes … are the urban Indian populations who aren't near an Indian Health Services facility and not near a Self-Governance facility and don't really have access to services. … and they vary, and they don't have the same budget authority because the government-to-government relationship

is between the Federal government and Tribes, not the Federal government and Tribal citizens. That's why we have the I/T/U model to make sure all three groups of services are always included"

5.5.2.9. Threats to sovereignty and unity

One of the Tribal participants has written extensively on Self-Governance and noted that despite historical government policies which aimed to divide Tribal communities, Tribes had survived these attempts and were working together very effectively in many areas.

"Federal Indian policy here has vacillated between isolation and assimilation. In 1887, Congress instituted a program of forced assimilation in the General Allotment Act. The avowed goal was to "civilize" Indians by breaking up communal life and making them individualistic farmers."

5.5.2.10. Critique

Research as part of the broader work by the Harvard Project on American Indian Economic Development (Cornell & Kalt, 2000), emphasizes the importance of culturally matched governance structures and cautions against imposed unity. This perspective can be seen as challenging the concept of "Tribal Unity and a Shared Vision" as a critical success factor in the framework for Tribal Self-Governance, through the commentary on cultural match versus imposed unity. Kalt and Cornell argue that governance structures need to align with the cultural, social, and political contexts of each Tribe. This concept of "cultural match" suggests that governance should be organically developed based on the specific traditions and values of the Tribe, rather than being imposed from external sources or through a forced sense of unity. Furthermore, the emphasis on "Tribal Unity and a Shared Vision" could be seen as potentially counterproductive if it leads to a homogenized approach that does not respect the diverse identities and needs of different Tribes.

Kalt's research suggests that such unity, if not culturally grounded, may undermine the effectiveness of governance by not adequately reflecting the community's unique characteristics and priorities. Deloria and Lytle agree that imposed unity may not reflect the true aspirations of all Tribes and could lead to governance structures that are not fully supported by the community (Deloria & Lytle, 1998).

Cornell and Kalt found that Tribes with governance structures that are stable, legitimate, and culturally appropriate are more likely to experience economic prosperity (Cornell & Kalt, 2000). This insight challenges the CSF framework to ensure that economic strategies are integrated with governance practices that are culturally matched and community-driven. While unity is important, Cornell and Kalt's emphasis on cultural match suggests that unity should not be imposed but should arise organically from shared cultural and social values. This challenges the notion of a singular vision if it does not resonate with the diverse identities within and among Tribes.

5.5.3. Flexible funding and revenue

Both the key informants and the review of literature strongly support the need for flexible funding arrangements and access to other revenues, but they also point to the need for ensuring equitable and continuous funding to support Self-Governance.

5.5.3.1. Monitoring the budget and advocating for flexibility

One Tribal participant placed high importance on funding for Tribes to give effect to TSG stating that:

> *"you must start with the Office of Management and Budget (OMB). We need an Indian seat at the OMB because there are very high- level decisions that get made at that level and we don't have a voice there … they're the ones that scrub the budgets and make the recommendations to the President about the budget"*

Other Tribal participants felt that the greatest challenge to Self-Governance is funding.

"I think that obviously it's money. I think funding is the greatest challenge … All Federal programs are underfunded that serve Indian country. So, I think that we definitely have seen that those Tribes with sort of the diverse economies and an economic base, they're able to supplement their health programs when they take it over from IHS or they're able to then, get significant funding through third party reimbursement or philanthropic grants which the Federal Government can't do."

"You're taking over an underfunded program. And that can be scary for some folks. Other than that, I think that the community resistance to change within Tribal communities is a great challenge. And the bureaucratic resistance is kind of a third one"

5.5.3.2. Barriers to Tribal access to new financial resources

Several of the key informants commented on barriers to Tribes accessing Federal resources with some Tribal participants stating:

"To the point of now when we're seeing new money come in from Congress to supplement programs, they're coming through grants, so they're not being put into to what we call Tribal shares that were contractable by for our programs under self-determination."

"At a budget summit for Indian Health Services . . . with people from OMB and from the White House and from Indian Health …we talked about how we could improve the system and how we could improve budgeting and how can we make it a different impact on how we look at Indian health. We're finding that all of the agencies at the Federal level are less inclined to put funding into Self-Governance through Self-Governance funding vehicles"

"Even when an agency is bound by policy to transfer governance of some of their programming to self-governing Tribes, some of their leadership are known to interpret the policy in a manner that puts barriers in place for the transfer of governance"

One of the Federal interviewees also noted that "*the IHS continues to address efforts regarding conversion of grant funding to programmatic funds that can be transferred through ISDEAA compacts and contracts*."

5.5.3.3. Severe Under-funding of the Indian Health System

The issue of under-funding for the Indian Health Service has been one raised by Tribal leaders for several decades and its impacts are far-reaching. At all of the TSG conferences that I attended, the issue of the under-funding of the IHS was a key topic. There is no doubt that Native American health care has been chronically under-funded, and it is one of the reasons that the need for flexible (and equitable) funding is a critical success factor for TSG.

In 2016, IHS health care expenditures per person were only $2,834, compared to $9,990 per person for Federal health care spending nationwide (National Tribal Budget Formulation Workgroup, 2017). In 2017, IHS health care expenditures per person were $3,332, compared to $9,207 for Federal health care spending nationwide. According to the National Congress of American Indians (NCAI) submission on the Federal appropriations for 2017, although funding for IHS had increased significantly since 2009,

"when compounded with rising medical inflation and population growth, Indian health budgets are quickly trending backwards. Indeed, when adjusted for inflation and population growth, the IHS budget has remained static in recent decades, with little additional funding available to target the chronic health disparities facing Native communities" (National Congress of American Indians, 2016, p.3).

The work of the National Tribal Budget Formulation Workgroup described earlier in this document highlighted in their 2005 report that the financial gap between the current budget at the time and the necessary budget to fulfil their program and service needs for the AI/AN population – was **$32 billion**. The report noted that the U.S. spends nearly twice as much on health care for prisoners as it does for Americans Indians. Federal appropriations for the Indian Health Service amounted to $2,130 per person in 2005, while, per person, it spent $7,600 for Medicaid; $5,200 for the Veterans Administration; $5,000 for Medicare; and $4,000 for the Bureau of Prisons (National Tribal Budget Formulation Workgroup, 2020).

In a 2003 report (U.S. Commission on Civil Rights, 2003) entitled "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country", the U.S. Commission on Civil Rights took on the task of evaluating budgets and expenditures of the [six] major Federal agencies sponsoring Native American programs. In the report, a majority of the U.S. Commission found that "funding for services critical to Native Americans—including health care, law enforcement, and education—is disproportionately lower than funding for services to other populations."

Twenty members of the United States House of Representatives sent a bipartisan letter to the Commission on May 14, 2015, requesting an update to A Quiet Crisis (Kilmer, 2015). The letter asked the Commission to update the 2003 report "*to help ensure that the Federal government is making progress in fulfilling its trust and treaty responsibilities*." Congress requested that the updated report include an:

> *"assessment of whether the Federal government is now better meeting its responsibilities to Tribal members; what efforts the Federal government has taken to implement the Commission's 2003 recommendations—specifically with regard to infrastructure development; and what actions, if any, are needed to best address the unmet needs in Indian Country to uphold the Federal trust responsibility and achieve Self-Governance for Indian nations." [Broken Promises Report, USCCR, 2018, p.15]*

In December 2018, the U.S. Commission on Civil Rights released the report: Broken Promises: Continuing Federal Funding Shortfall for Native Americans (U.S. Commission on Civil Rights, 2018) as an update to the 2003 report described above. Despite some progress, the crisis that the Commission found in 2003 remains, and the Commission found that the Federal government continues to fail to support adequately the social and economic wellbeing of Native Americans. The 2018 report highlighted the following findings:

> *"Federal programs designed to support the social and economic wellbeing of Native Americans remain chronically underfunded and sometimes inefficiently structured, which leaves many basic needs in the Native American community unmet and contributes to the inequities observed in Native American communities. The Federal government has also failed to keep accurate, consistent, and comprehensive records of Federal spending on Native American programs, making monitoring of Federal spending to meet its trust responsibility difficult. Unequal treatment of Tribal governments and lack of full recognition of the sovereign status of Tribal governments by state and Federal governments, laws, and policies diminish Tribal self-determination and negatively impact criminal justice, health, education, housing and economic outcomes for Native Americans." [Broken Promises Report, USCCR, 2018, p.17]*

The Commission majority voted for key recommendations, including the following:

a) The United States expects all nations to live up to their treaty obligations; it should live up to its own.

b) Congress should honor the Federal government's trust obligations and pass a spending package to fully address unmet needs, targeting the most critical needs for immediate investment.

c) This spending package should also address the funding necessary for the buildout of unmet essential utilities and core infrastructure needs in Indian Country such as electricity, water, telecommunications, and roads.

d) Congress should ensure that these funds are available and accessible to all Tribal governments on an equitable need basis.

The Commission's 2018 follow-up study reflected that the efforts undertaken by the Federal government in the prior 15 years since 2003 had resulted in only minor improvements for the Native population, and that "*in some respects, the U.S. Government has backslid in its treatment of Native Americans*." The National Indian Health Board affirmed the Commission's findings in a submission on their report, stating that:

> *"Federal funding for Native American programs across the government remains grossly inadequate to meet the most basic needs the Federal government is obligated to provide. Native American program budgets generally remain a barely perceptible and decreasing percentage of agency budgets. Since 2003, funding for Native American programs has mostly remained flat, and in the few cases where there have been increases, they have barely kept up with inflation or have actually resulted in decreased spending power and that "the overall Indian Health Service (IHS) budget meets just over half of the health care needs of Native Americans who suffer striking health deficiencies and disparities." (National Indian Health Board, 2018, p.3)*

One of the Commission's most significant recommendations from their 2018 report was for Congress to honor the Federal government's trust obligations and pass a spending package to fully address unmet needs, targeting the most critical needs for immediate investment in particular:

"Increased, non-discretionary, and advance appropriations for IHS to bring it to parity with other Federal health programs, such as the Veterans Health Administration, including for facilities and urban Indian health". (National Tribal Budget Formulation Workgroup, 2018).

One of my Tribal interviewees was one of several key informants who stressed that funding is a critical issue for TSG, stating that

"one of the things that's always very discouraging is the fact that Indian health is so under-funded, and I see that that's a real barrier to Tribes desiring to participate in Self-Governance. All Tribes want to be self-governing, but they're very fearful of the fact that if they take over the system from the Federal side of things those direct service Tribes are very worried that they won't be able to provide the same level of care. But the Tribes that took that leap of faith have done a good job with it"

Another Tribal participant also raised issues about the budget formulation process of the Federal government and severe inequitable and under-funding, and in particular that formulas are applied differently across the regions of Federal agencies such as the BIA, making national rollup of budgets very challenging. They added comparisons of Federal appropriations to Tribes compared to U.S. Foreign Aid appropriations.

A Tribal participant noted that foreign aid assistance, which comprises military and economic assistance, is given by the U.S. to developing countries, countries of strategic importance to the United States, and countries recovering from war. In FY2012: $48.4 billion dollars (Military Assistance: $17.2b, Economic Assistance: $31.2b) was provided and in FY2013: $50.6 billion dollars. In comparison to the $32b gap identified in the IHS budget by the National Tribal Budget Formulation Workgroup in 2003, the inequity was stark.

The Hon. Clifford Marshall, Chairman of the Hoopa Valley Tribe, described in a statement to the Senate Committee on Indian Affairs (*"Statement of The Hon. Clifford Marshall, Chairman of the Hoopa Valley Tribe." Reviewing the Success of Self-Governance after 30 Years*, 2018), that:

> *"Evidence of chronically underfunded Indian programs, sometimes as much as 75 percent within the BIA and IHS budgets, has been well-documented over the past several decades. Many Tribes hesitate to assume Federal programs under Self-Governance because they understand there is not adequate money to support the Tribe in carrying out the functions of the programs that the Tribes want to administer. … At Hoopa, we can show that the Tribe matches $3.00 from other sources for each $1.00 compacted from the BIA" ("Statement of The Hon. Clifford Marshall, Chairman of the Hoopa Valley Tribe." Reviewing the Success of Self-Governance after 30 Years, 2018).*

5.5.3.4. Flexible use of funding

One of the Tribal participants commented on the importance of Tribes being able to use the funding they receive in a flexible manner, so that they can adjust to the needs of their own populations. This included the ability to be creative with resources and fully exercise their ability to use the resources as they saw fit, and to access other resources. They stated:

> *"I think the other thing that has made Tribes super successful is the fact that they really pushed the boundaries and the letter of the law … they really try very hard to exercise all the authorities that are given to them under the law ... the Tribes that have been most successful understand all of the avenues that are available to them to supplement their funding. It's a long game."*

A Federal interviewee confirmed that the IHS works with Tribal leaders constantly to support their efforts to get more resource into IHS funding agreements stating that

"Self-Governance has a lot more flexibility of course…but all the monies that are currently identified as competitive … they would like to see all those funds go into a formula instead of through competitive grants"

One of the Tribal participants also commented on budget management and the opportunity for increased flexibility stating that:

"Tribes do decide what they want to administer and what they don't. So, they're germane to certain Tribes and not to others. But a great example is health and human services… there's 554 grants that Indians are eligible for in Indian Health Services. If you could lump all those grants into one funding vehicle, wouldn't it just be so effective?"

5.5.3.5. Contract Support Costs

Contract Support Costs (CSC) are, as the title shows, those costs needed to support contract management and delivery – essentially the governance, corporate and back-office functions. In the contracting and compacting process, the Tribes have been advocating for many years to have these costs properly covered to avoid them having to be deducted from front-line service delivery budgets.

For well over a decade, the Tribal Self-Governance program has provided limited funding to cover these costs for managing compact agreements as often what is included in compact agreements falls well short of the true costs. In my time observing the Tribal Self-Governance system I have certainly attended many conferences and breakout sessions where Tribal leaders have advocated strongly for payment of CSC. For decades the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) underpaid the amount of CSC that were due to Tribes and Tribal organizations that contracted to operate IHS clinics and hospitals and BIA law enforcement, realty, housing and other government programs under the ISDEAA (Self-Governance Communication and

Education Tribal Consortium, 2015). The failure of Federal agencies to pay full contract support costs was the one most frequently raised by Tribes and Tribal organizations ("Menominee Indian Tribe of Wisconsin v. United States," 2016).

The SGCETC's white paper (Self-Governance Communication and Education Tribal Consortium, 2015) stated that in June 2012 the Supreme Court (for the second time) held the government liable for $940 million in contract underpayments in their decision on a Tribal lawsuit ("Salazar v. Ramah Navajo Chapter," 2012) and that this built upon an earlier, unanimous Supreme Court decision in a Tribal lawsuit against IHS ("Cherokee Nation of Oklahoma v. Leavitt," 2005). (Krepps, 1991) affirmed that a primary disadvantage to contracting with Federal agencies is the shortfalls in contract support funding. In his report he stated that several Tribal officials had confirmed that the amount of direct program funding they received when they contracted to administer their own programs was not sufficient to provide the adequate level of service to Tribal members, and that their contract programs did not receive full funding to cover the indirect, support, or start-up costs that Tribes incur as part of managing these contracts. Krepps noted that BIA and the IHS estimate that total administrative funding shortfalls arising from the contracts they funded during fiscal years 1993 through 2002 ranged from a low of about $25 million to as much as $130 million annually. Krepps notes that as a result, Tribes have had to cover the shortfalls with Tribal resources and at times reduce program capacity, and for some Tribes the threat of, or actual funding shortfalls, discouraged them from entering into or continuing contracting arrangements with the Federal government (Krepps, 1991).

The NCAI (National Congress of American Indians, 2015) adds that historically contract support cost shortfalls have penalized Tribes in the exercise of their self-determination rights under the law. Contract support costs are the key to self-determination for Tribes – these funds ensure that Tribes have the resources that any contractor would require to successfully manage decentralized

programs. Tribal leaders across Indian Country have repeatedly emphasized the importance of fully funding contract support costs.

Although this issue was later settled after a Supreme Court decision leading to large scale settlements being paid out from 2015, the failure to pay full contract support costs threatened the integrity of both Title I contracting, and Title V compacting, because the Tribes did not have the same resources to support the administrative requirements for programs as the IHS had. It also impacted the decisions on whether Tribes chose to engage in 638 contracts/compacts because of the uncertainty around contract support costs, and their ability to bear the administrative costs until the costs could be reimbursed or paid.

5.5.3.6. The health resource can be a key contributor to Tribal economies

A Tribal interviewee stressed the importance of health funding in Tribal communities as a key contributor to the local economy, explaining that:

> *"Money circles around…we're trying to make a well community and a healthy community. Instead of spending our money outside of our community, we started spending our money locally, so we build a healthier economy … a health business is a big economic engine within your community. We keep the money in our community, and that contributes to wellness. Make that a plan of your strategy, as really looking at local native employment"*

An example of the economic benefit of self-governing Tribes to local economies was provided by the Hon James Steele Jr, Chairman of the Confederated Salish and Kootenai Tribes, in his testimony at the 2008 Senate hearing on Self-Governance. He stated:

> *The Indian Self-Determination Act of 1975 and the Tribal Self-Governance Act of 1994 have been two of the most successful and important pieces of Federal Indian legislation in the history of this Country. The last 20 or 30 years have seen great changes in Indian*

Country . . . a recent report funded by the State of Montana showed that the Confederated Salish and Kootenai Tribes contributed $317 million a year to the Montana economy through our success in operating our large electrical utility… (United States Senate, 2008).

5.5.3.7. Critique

While equitable funding is a critical factor, researchers (Cornell & Kalt, 2000, 2010) point to the need for systemic changes in how resources are allocated and used. Simply achieving funding equity may not address deeper structural issues that affect Tribal governance, self-determination, economic sovereignty and reduction in dependency on external funding sources.

Research by (Sequist, Cullen, & Acton, 2011) underscores the difficulty Native Americans face in accessing culturally conscious care, which is crucial for improving health outcomes. This highlights the need for health care systems to be designed with cultural considerations at the forefront. While one of the factors addresses equitable funding, Sequist and co-authors further suggest that funding should also support initiatives that enhance cultural competence and reduce barriers to culturally conscious care. This might include funding for training programs or culturally tailored health care services.

The study by Indigenous health researcher Dr Donald Warne and Cherokk and Lakota scholar Dr Linda Bane Frizzell provides a comprehensive overview of the historical and contemporary issues in American Indian health policy (D. Warne & L. B. Frizzell, 2014). Warne and Frizzell's analysis underscores the need for not only equitable funding but also structural reforms to ensure that resources are effectively used to address health disparities. This challenges the CSF framework to consider broader systemic changes beyond funding equity. They highlight how federal policies have often been inadequate in addressing the unique health needs of Native communities, which can challenge the CSF of "Equitable Funding and Revenue." The need for

equitable funding is emphasized, but Warne and Frizzell's work suggests that systemic policy changes are also necessary to address long-standing disparities. One such example is the disparities in mental health. Duran and colleagues (Duran, 2002; Duran & Oetzel, 2005; Duran et al., 1998) address the need for equity in mental health services, which can be extended to the broader context of health care equity and supporting specific health disparities faced by AI/AN communities. This suggests that the CSFs should consider how funding can be used to support culturally tailored health interventions. Jernigan and colleagues (Blue Bird Jernigan et al., 2015; Blue Bird Jernigan et al., 2012) also identify significant health disparities faced by Native American populations, which can be exacerbated by a lack of culturally competent care.

5.5.4. Qualified workforce

There were several comments made about the importance to TSG of having a qualified workforce from leadership through to front-line health care practitioners.

5.5.4.1. Workforce shortage is a critical issue

For the Indian Health Service this was one of their most critical issues with one of the Federal interviewees stating:

> *"Workforce is the biggest challenge in Indian Health. I think that's the root cause of many of our issues is not being able to find or develop enough qualified individuals to run the systems."*

The same interviewee identified that despite the workforce shortage, one of the existing strengths in the IHS was that 70% of their employees were American Indian or Alaskan Native, and that this high rate of Indigenous employees was due primarily to the Indian Hiring preference policy for the IHS:

"That's an important piece. Because that gets back to the treating our own . . . and by extension all the Tribes of course have their own Indian preference hiring. They can even do Tribal preference for their own Tribe"

Another Federal participant agrees that workforce gaps in IHS is a huge challenge.

"Our biggest challenge at IHS is the workforce. We carry a high vacancy level and that's been consistent for a few decades. It seems the Tribes do a better job of recruitment than the IHS where we are often in a position of not being able to compete with the marketplace"

A Tribal participant agrees that the lack of an available professional workforce is a major issue.

"It's not just, not enough doctors, not enough nurses, but not enough administrators and governors and people who can take on that role. I would say that you would want to make sure that you have workforce development. We keep talking about having an executive association or whatever in place at the national level to help out Tribes that are struggling with managing their health programs"

One of the Federal interviewees stated that it was a very competitive market and attracting people to work in Indian Health was always challenging.

"Now we have competing industries. Now we've got managers and financial experts who are excited to work in different sectors. So, it's diminished our pool. And then you've got to have the numbers coming through school who want to get into the health care industry at all and live at home. Living at home is the biggest challenge, because even when we recruit non-Natives to come into our communities, it's got to be careful recruitment

because you're recruiting the whole family. They're going to be going to the schools in the community. Available, stable, adequate housing is another challenge"

5.5.4.2. Tribal capability is often under-estimated

One Tribal participant described his experience growing up around Tribal leaders in the early days of exploring Self-Governance.

"A lot of people that were working in programs and services, they hadn't even completed college and probably only had a high school level of education … through the school of hard knocks became very experienced administrators and could compete in the world of people that had four-year degrees in MBA types. Now things have changed and… our people are highly educated now. I think that's just one of the processes of self-determination."

Another Tribal participant agrees that often the skills of Tribal administrators are underestimated.

"Good credible people, they just didn't feel that the Tribes had the expertise to do it. They felt we lack the education, lack the competencies, lack the experience to be able to pull this off. There was some of that…and as we took over more of the program, the system didn't think we could do it"

5.5.4.3. Challenges and strategies for recruiting workforce to Tribal areas

One Tribal interviewee said that successful Tribal organizations focused on training and strong onboarding orientation.

"Making sure you have that training or onboarding orientation, whatever you want to call it, for everyone frequently. That includes not just the people that are on the governing

body, but also the community, having the community understand that. Everyone must know what the Tribal organization is about, what it is aiming for, what is important and what it believes in … so that as employees they know what they're stepping into."

The NIHB also advocates for more tools and incentives being used by the IHS to attract medical professionals and health administrators to remote areas as noted by one of the Tribal participants.

"It begins to address setting competitive pay scales for IHS employees that would be comparable to other physicians, dentists, nurses, and other health professionals."

One Tribal participant noted that the United States trains medical residents, as well as dentists and some nurses, through an entitlement program, Graduate Medical Education (GME), within Medicare. The GME program exceeds $15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. The NIHB identified that a potential opportunity to increase the number of physicians serving in Indian Country was to set aside a certain number of new residency training positions for those willing to serve in Indian Country. This participant explained that:

"In States like Connecticut, where residency training positions are approximately $155.000 per resident per year, that is an astonishing incentive to complete service to Indian Country. We must make IHS a desirable place to work. Time and again, NIHB hears from physicians who leave IHS and cite the obstacles to working at these poorly operated facilities."

Another Tribal interviewee described challenges for Tribes taking ex-Federal employees when assuming Self-Governance explaining that:

"The problem is that when you take somebody from the Federal system, they need to understand that working for a Tribe is different. Imagine all of your patients living in your neighborhood and seeing you at the shop and seeing you at the grocery store. Then calling you up after hours and at weekends. It's a completely different thing."

One Tribal interviewee also identified other issues that impact recruitment of workforce to rural communities stating that:

"I will tell you that the biggest challenge for Tribes that are in remote areas is the lack of broadband and being able to do distance learning right? … being able to educate people in their own communities because it's very hard to recruit to those rural communities. So, to me, the goal is to begin educating as much as you can people in your own community to take over these."

I met with some of the Native Nations Institute (NNI) representatives at their exhibition booth at the NCAI Annual convention in Albuquerque in October 2019. I was very impressed with the courses they offer for Tribal leaders and in particular the availability of a Master of Professional Studies in Indigenous Governance. There are options available for short courses on specific subjects (e.g. Indigenous Data Sovereignty or Tribal Business Law), and the partnership with the University of Arizona means there are many more qualifications on offer. The importance of having these courses and qualifications available through the NNI partnership with the University of Arizona means that there is continuity and sustainability for this to be available for new, emerging or current Tribal leaders. This is especially important since there is often turnover in leadership through Tribal elections processes and having educational opportunities like this available, means there are always formal learning opportunities for emerging and new leaders. This is just one example however of academic institutions partnering with Indigenous organizations to offer tailored and meaningful education that supports Tribal governance.

5.5.4.4. Critique

The focus on developing a qualified workforce is important, but Kalt's research (Cornell & Kalt, 2000) indicates that cultural competence and the integration of traditional knowledge are equally crucial. This suggests that workforce development should not only focus on formal qualifications but also on culturally relevant skills and knowledge.

Native American physician Dr Tom Sequist and colleagues (Sequist, 2021; Sequist, Cullen, & Acton, 2011; Sequist et al., 2005; Sequist, Cullen, Bernard, et al., 2011) point out the need to increase the recruitment of Native American physicians to reduce cultural barriers. This aligns with the CSF of "Workforce Capability and Development," emphasizing the importance of a workforce that is not only qualified but also culturally competent. The study challenges the framework to go beyond formal qualifications and focus on cultural competence as a critical component of workforce development. This includes training health care providers to understand and respect the cultural contexts of the communities they serve.

Warne and Frizzell agree that workforce development includes training in culturally relevant care practices, not just formal qualifications (D. Warne & L. B. Frizzell, 2014). The study by Indigenous health researcher Dr Donald Warne and Cherokk and Lakota scholar Dr Linda Bane Frizzell provides a comprehensive overview of the historical and contemporary issues in American Indian health policy, and they emphasize the importance of culturally competent care in reducing health disparities among Native populations. This aligns with the CSF of "Tribal Identity and Culture," but also highlights the need for health care workforces to be deeply integrated with cultural practices and knowledge.

Researchers (Blue Bird Jernigan et al., 2015; Blue Bird Jernigan et al., 2012; Duran, 2002; Duran & Oetzel, 2005; Duran et al., 1998) suggest that interventions recognizing and promoting community strengths can be effective. This supports the idea that governance and health care

delivery should be community-driven and culturally informed, challenging the CSFs to ensure that Tribal governance structures are not only top-down but also incorporate community input and strengths.

5.5.5. Robust data and information

5.5.5.1. Data and Information is critical to sustainability of Tribal Self-Governance

One Tribal participant affirmed that data and information are essential to effective Self-Governance but is an area that has not been paid enough attention to historically.

> *"I am glad to see this issue mentioned here. We didn't really pay attention to data collection and reporting as much as we should have. We just wanted control from the Federal government, we wanted to stop collecting and reporting what we saw as meaningless information to government, and we wanted to measure things in our own way. But we didn't really put effort into figuring out how we were going to do that. What were we going to measure? It's really something we are playing catch-up on now…so yes this is definitely a priority."*

A Tribal interviewee from one of the national Tribal organizations agrees that sound surveillance data is necessary for an effective Tribal health system. They identified that

> *"Bolstering Tribal public health surveillance infrastructure is a major need. The CDC in 2017 stated that the actual drug overdose death count among AI/ANs may be underestimated by as much as 35% due to racial misclassification on death certificate data. That is truly unacceptable. Data is the backbone of any public health system, and without it the Tribes and IHS are unable to maintain accurate records of vital statistics, to quantify disparities in health outcomes between AI/ANs and other populations, and to*

ultimately make true assessments of need. More importantly, Tribal leaders must have this information to make informed policy decisions and implement targeted programs."

Another Tribal participant added that:

"I would say, make it a conscious decision to invest in it from the very beginning, because you need that to tell your story of how well you're doing and what you're doing. The Tribal Epicenters in the United States, they haven't gotten an increase in funding in years. I would say, make a conscious decision to invest in that piece of it, because that's where you're going to get the long-term sustainability for your programs and services."

One Tribal participant currently oversees an organization with a Tribal Epicenter and has been doing so since 2001, and while they see value in data, they are concerned that as sovereign nations they should not have to present data to the Federal government to meet what they see as their right to access.

"We know we need it, but we shouldn't have to do it for the Federal government's purposes as sovereign nations. Facts and data don't help when you have a level of racism among decision-makers. Take voting – we have two main Democratic and Republican parties - we end up choosing the lesser of our oppressors."

5.5.5.2. Using data to tell the story for more resources

A Tribal interviewee had a particular interest in data, health technology and performance measurement and saw this as a critical issue for Tribes and recommended that it is an area requiring investment up front and that it is likely their greatest challenge at present. They stated:

"Data and performance measurement and how you get a national picture, and electronic health records. Invest in it. Find a way to invest in that. That is the biggest problem we have really . . . This is what I see in other parts of the government."

This participant identified that in other parts of the DHHS, there were strong examples of data and information being used in a smarter way to present their achievements and that often led to easier access to funding, advising that

"Community Health Centers for instance are like a competitor with the Tribal Health system because we all get our money from the same place – the DHHS. We're not really doing anything like that, to market what we achieve….one of our biggest failings, I think, is our ability to really advance our budget, and I said this at national meetings, is we need to beef up our data and how we collect it, and what we collect and what we choose to present in a more strategic way than what we do now."

Another Tribal participant also commented on the need to be clear on the audiences for data and information and how best to present it

"You can use data internally for patient care and things like that, but it's really, you have to pay attention to, what's purpose of this information? who's the audience and how are we going to make it work for us?"

It was added by another Tribal participant that the absence of good data to help with advocacy doesn't mean Tribes have to relinquish data control to the Federal government saying

"Part of Self-Governance is you're not required to report. We're not required to report anything, and I understand why that was put in because of Tribes again, don't want to put the whole system at a disadvantage. So, I understand why that was put in. I think if we

could do data in the aggregate as opposed to individual Tribes being identified, I think people would be more comfortable with that"

A Federal participant confirmed that data and measurement was vital, but also that the voice of community leaders and citizens was just as important in telling the Tribal health story, saying

"Speaking with individual community members who may be impacted is good practice – some things they raise might be a local concern for local leadership to attend to, but if you bring people together regionally or nationally, you might find there is a pattern…so bringing people together is important to see how widely an issue might be impacting"

Another Federal participant also confirmed that a lot of effort was being spent on the data, measurement and the metrics and then bringing that information back to help with seeking the resources to address the problems.

"It is important for me through this lens of Indian Health Service, but I know that we have so many sister agencies out there with a lot of resource, Center for Disease Control, National Institute of Health, who can invest as well to help address health issues. We can help as the internal advocate to go in and speak to our sister agencies and share the data and highlight the need and validate the need"

5.5.5.3. Health Information Technology

One Tribal participant participated in the Health IT Modernization Project as they recognized the need for a major investment in this area to enable Tribal health to be smarter about how the system collected and reported its data to benefit Tribes. As part of the project, they stated

"We interviewed both Tribal sites, IHS sites, urban sites, and we had a commission of industry experts that weighed in on this. We just got a lot of feedback. We did data calls.

This [Health IT Modernization] report's going to have a lot of good information about what kinds of things you need to be aware of if you're looking at health IT modernization.""

Referring to Tribal assumption of the RPMS system from the Indian Health Service, the same participant stated

People had either kept on going with the federal system and it was like, well, at least it had a track record. At least it had a history that you could sort of build and say, here's how it looked under IHS and here's how it looked with us, utilization and whatever. Then there were those who dropped that system and went off on something else. Nobody is working to a common set of measures that the Tribes want, not that the government wants, but that the Tribes want."

Another Tribal participant also discussed the fact that Tribes were using different health software

"the data piece, we use different systems, some are still on the IHS system, some bought new software, and it doesn't do this, but it does do that. You know what? I think it depends kind of what type of data you need . . . if you're looking for data to kind of just document health outcomes and population, demographic data, economic data, educational, I think that's out there in the system already. I think the type of data that you're talking about is talking about health-related data once we take over management of a health program so that we can consistently capture or report data measures that can be used to evaluate outcomes in order to justify the money that we're receiving and also substantiate and justify more money for what it is we're doing".

The same participant also identified that one of the reasons that health technology and data were likely not taken as seriously when TSG started, is that technology was not as advanced or prevalent as it is now.

> *"I think part of the challenge for what we're dealing with right now … is that we're a product of the technological evolution of information technology in that when we first took over programs nobody knew how or what type of data to use. The choices that you have are going to be much different than the technological choices that we had to make way back when self-determination started. In fact, the rest of the private sector was contributing 15 to 20% of their money into the development and maintenance of data and health. And we weren't. We implement I think it's less than 3% of our budget goes for data. The one thing I would recommend to you all as you move forward is get on the same page about data and get the interoperability of the systems in place."*

Almost 20 years ago, one of the Tribal participants recalled an information systems advisory committee being established to consider the cost benefit of continuing to use RPMS or to migrate to an off the shelf system. A study was carried out by a group of economists and technology experts who estimated that the cost to maintain RPMS was *"something in the neighborhood of $650 million to catch it up to the point where it was consistent with an off the shelf system*." They also identified that likely most Tribes and IHS sites had outdated hardware to manage a significant software system.

> *"I think by the time we costed it out to look at software, hardware, training, implementation costs it was something in the neighborhood of $1.5 billion. It just became overwhelming. But we sat there and said let's go for the $1.5 billion special appropriation from Congress and we're on our way. Well, it wasn't as simple as that. The $1.5 billion I think was about 50% of the agency's budget at the time. So, it really wasn't the return on*

investment and the opportunity costs to move away from RPMS was a no brainer, but capitalization costs were the big elephant in the room that we couldn't overcome."

Another Tribal participant agrees investment in health information technology and good data is essential for Tribal leaders and to support advocacy work, stating that:

"Self-governing Tribes, those who've got frustrated with RPMS have said oh blow it, we're going to get our own. So now we have all these different systems across the states - that don't get into anything so we're not advocating it the best way we can because we don't have the data. So, I do think even if Tribes end up buying their own system because it's more facile to use an over the counter or off the shelf system, there needs to be a way to migrate data into the overall system. So, it's a fractured system in that regard. I mean my recommendation would be it's fine for Tribes to manage their data in any way they see fit, but there needs to be some coordination".

Another Tribal participant added that:

"Tribes also remain behind many other communities in their public health infrastructure, capacity, and workforce capabilities as a result of being largely left behind when the United States was modernizing its public health infrastructure. These obstacles have made it particularly difficult for Tribal communities to assemble a coordinated and comprehensive defense against major health emergencies, including the opioid epidemic".

One of the Tribal participants oversees a Regional Extension Center (REC) which is an organization that has received funding under the Health Information Technology for Economic and Clinical Health Act (HITECH Act) to assist health care providers with the selection and implementation of electronic health record (EHR) technology ("Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the

American Recovery and Reinvestment Act of 2009," 2009). Under the HITECH Act, RECs have three specific objectives:

- Provide training and support services to assist in EHR adoption.
- Offer information and guidance with EHR implementation (but not to carry out such an implementation).
- Give other technical assistance as needed.

The REC program seeks to support 100,000 primary care providers, with particular emphasis given to medical practices with fewer than 10 clinicians and clinicians who work in settings that tend to serve uninsured, underinsured, and medically underserved populations. To date, $677 million has been awarded to 62 RECs, each of which covers a distinct geographic area. Some RECs plan to produce a list of preferred EHR vendors toward which they will steer providers who need to implement EHR technology. The objective is twofold: one, to help providers narrow their choices among an estimated 300 EHR vendors, and two, to allow RECs to focus their efforts and knowledge on a small number of products. In their area, the Tribal participant stated that agreements have been signed with member Tribes for all access to their records as Data Sovereignty is important with Tribes. There is to be no publicizing of any data without their consent. "*We do use data for advocacy purposes only with the consent of Tribes, so with all of them using the EHR and us having direct access to roll up aggregate data, it really helps.*"

5.5.5.4. Tribal Research and Data Sovereignty

One Tribal interviewee identified that research projects are an essential part of governance because

> *"You have to have control of any research that's done, because you know, our people have had things done to them over the years. That's the other unique part of a thing you need to*

sell to your own people is, hey, we're in control and we can decide what's important and what we want to look at and how we want to do research."

Another Tribal participant raised the importance of Data Sovereignty.

"One of the things that we've been dealing with and not just with health care data, but data sovereignty and protecting data, those types of issues. There is an Indigenous data sovereignty network out of Arizona. And I know they did a lot of work in New Zealand, Australia, and it kind of became, they got interconnected with these different global Indigenous data sovereignty groups. And it's a very academic type of approach to data sovereignty. And we're trying to figure out, moving from an academic approach to data sovereignty, how do we move this into a practical, governance type of realm".

5.5.5.5. Evaluation

Representatives of self-governing Tribes provided guidance and input to a project assessing the feasibility of TSG (Westat, 2003) and they emphasized a number of points that were important to them.

- Many Tribes are convinced that Self-Governance is a successful and effective mechanism for providing services to Tribal members by ensuring services are available to Tribal members and designing programs to meet specific Tribal priorities and circumstances.
- Many Self-Governance Tribes understand and support the concept of evaluation and recognize the benefits (improved data systems/data availability, evidence of the effectiveness and success of Self-Governance, and information on "best practices" for management)

- DHHS provides for the costs of any evaluation's data and reporting burden on Tribes. Tribes are also concerned that these total costs are justified by the potential benefits that might be obtained from an evaluation.
- Any evaluation design should consider the goals and principles of Self-Governance. Self-Governance offers Tribes the opportunity for flexibility to develop and re-structure programs to meet specific Tribal objectives. Any evaluation design should be similarly flexible in defining the outcomes that would be measured.
- The design of any potential evaluation should also consider the fact that Tribally-managed programs are under-funded. This is a particularly important consideration if external comparison groups/strategies were to be used in an evaluation, since joint Federal-State funding of some programs is considerably higher than the funding provided to Tribes for those programs.

(Westat, 2003) identified that there was little quantitative evidence on the quality of care of Tribally managed health programs and how patterns of care or outcomes may differ from health programs operated by the IHS. One measure of quality – average wait time – was identified through the NIHB survey (National Indian Health Board, 1998) which indicated that 86% percent of Tribal leader respondents from compacting Tribes noted improvements in wait times improved during this time period. Approximately 94% of Tribal leaders and Tribal health director respondents from contracting and compacting Tribes perceived an improvement in quality of care.

5.5.5.6. Critique

Kukutai and Taylor advocate for the decolonization of data practices, which involves replacing external norms with Indigenous systems of data governance (Kukutai & Taylor, 2016). This is crucial for ensuring that data reflects Indigenous understandings and supports their strategic goals. The CSF framework emphasises the importance of technology and data, but Kukutai and

Taylor's work challenges it to ensure that these systems are governed by Indigenous communities. This means that data governance should be an integral part of the framework, with a focus on Indigenous control and sovereignty over data.

5.5.6. Successful partnering

Key informants and other evidence highlighted a number of positive partnerships within the Indian health system and the need for this to be included as one if the critical success factors. One Tribal interviewee stated

> *"Partnerships are everything. None of us can do this alone. We need everybody at the helm – Tribes, Federal and State governments, corporate sector, politicians and our national institutions – and our communities. We are all in this together and no Tribe can operate alone because so much of what we do is intertwined with other governments."*

A Federal participant stated

> *"We at IHS need the Tribes. We wouldn't want to be doing anything without their support. We must partner all the time. We may not always agree but we come together regardless and listen to each other."*

5.5.6.1. Tribal – Federal Partnerships

A Federal interviewee stated that the Tribal partnership with the IHS is critical.

> *"We have to stand together when advocating to government for resources or policy changes in Indian Health. We (IHS) cannot do it alone and we certainly wouldn't want to be pushing an agenda that was not in line with what self-governing Tribes want to do. We want to support their aspirations. We provide whatever we can in terms of technical support, information or advice to help advance the Self-Governance agenda. We are very*

strong believers in Tribal sovereignty and Self-Governance – but at a pace that Tribes themselves determine."

Another example of a key partnership for the IHS is with the Veteran Affairs (VA) as explained by the same participant.

"The AI/AN population experiences health and other disparities that disproportionally affect their quality of life (Indian Health Service, 2018). As health needs change and new approaches to care emerge, the IHS works with other Departments such as the VA, and their Tribal partners will continue to combine their expertise, resources, and efforts to help the nearly 145,000 AI/AN veterans living in the United States (Veteran Affairs, 2018)."

The Patient Protection and Affordable Care Act of 2010 (aka Obamacare) permanently reauthorized the IHCIA, and also directed the VA to reimburse the IHS, Indian Tribes, or Tribal organizations for the services provided to eligible beneficiaries of either Department in the respective facility. A Federal interviewee explained that:

"Since implementing this provision in 2012, VA has reimbursed over $103 million for direct care services provided by IHS and Tribal Health Programs, covering approximately 10,645 unique AI/AN veterans."

5.5.6.2. Tribal – State collaboration

Chief of Cherokee Nation, Chuck Hoskin, shared a story on their experience as a Nation working with their state government (Hoskin, 2020).

"In my years of service to the Cherokee Nation, I have seen how powerful it can be when our Tribal nation and the State of Oklahoma maintain a stable and positive partnership.

The Cherokee Nation's economic impact in our state – almost $2.2 billion – is rooted in our commitment to investing in Oklahoma communities, big and small. The Cherokee Nation will never outsource jobs or threaten to pull up stakes when the going gets tough. We remain the best friends that the State of Oklahoma has ever had … At Cherokee Nation, we do keep track of this data and use it to distribute nearly $6 million annually to public schools that serve Cherokee students within our jurisdiction in northeast Oklahoma"

5.5.6.3. Partnerships outside of Tribes and Governments

A Tribal participant highlighted that successful partnering needed to include other entities outside of the Tribes.

"One of the most interesting things for me is the amount of successful partnering that happens with other governmental entities outside of Tribes. With the State, with the Counties, with the local governments. We become very much another government that participates in all the other councils of government that exist in our regions and we become a value partner in a way that we weren't valued before. Also, successful partnering with the private sector. A good example is one that kind of I recently observed and that is with the internet providers in Alaska. Its regions are very isolated and distant and it's expensive to bring in broadband. But because the telehealth, because of the health system, there's so much telehealth and telemedicine, we use it. We bring down the cost of infrastructure for technology in other disciplines of the communities. So, we bring it down for health care, we bring it down for business, we bring it down for schools, for just anything else that your phone service, etcetera. Now we've become a very vibrant partner in the negotiation of bandwidth across the state of Alaska as a health care provider"

5.5.6.4. Critique

Lonczak and Tribal colleagues provide an example of a partnership between Tribes and an academic institution which identifies that partnering in itself is not sufficient (Lonczak HS, 2013). The quality of the process of partnership is equally as important as the partnership itself and this challenges this critical success factor in its current form. Successful partnering cannot be defined by economic or other outcomes alone, but by the quality of the partnering activity. Lonczak conducted a study of the quality of relationships across and between research teams in a university and Tribal partnership, grounded in community based participatory research (CBPR) and Tribal Participatory Research (TPR). The evaluation demonstrates the "evolution over time from different perspectives and two distinct research groups to a common vision, shared goals, and truly collaborative partnership based on the development of trust and community involvement and project ownership". From the perspective of the Tribal partner, for many AIAN Tribes, communities and individuals science is just another wave of groups wanting to "help" the Indians similar to the government, the army/military, the churches, etc.

Historically this meant that these non-Native entities imposed their own values of what type of "help" is needed rather than what the Tribe/community wanted or may have needed. Elder participants noted that researchers were committed to the importance of cultural humility and that the research that was guided by the Suquamish Tribe and was respectful, ethical, and effective. The partnership allowed for a different timeline – it was community-driven rather than grant-driven. Tribes need time to trust and "to think about what the implications of this relationship/partnership would mean and decide if it is a path they want to take and if it is the right time". Therefore, this CSF for successful partnering should be explicit about the quality of processes and relationships – not just outcomes from the collaboration.

5.5.7. Infusion of Indigenous culture

5.5.7.1. Culture and identity are important and variable

One Tribal interviewee affirmed that cultural identity was an essential component to TSG stating:

> *"If we don't keep our identity in this process, then what's the point? We just become brown people still managing a white system. That's been expressed by Tribes in Self-Governance in their design of their programs, or the look of their facilities or how they practice protocol at meetings. You see it all the time, so that you know, "Oh. I'm not in the typical government space, rather I'm in a Tribal space now".*

Another Tribal interviewee affirmed that cultural identity and expression is important to Tribal citizens and communities.

> *"The fact that you act, behave, focus on culture actually is, may not necessarily be important to the Federal government but it's certainly important to Tribal members to see that their culture is expressed throughout the Self-Governance model. Because no one wants the Federal government to come in and tell us what we need or how we should do it right? So, we believe our language restoration project and our drumming, and our dancing are all contributors to our overall health. They are those health indicators, they're the social determinants of health for us and you can't separate one out from the other"*

One of the Federal participants noted that culture is important but also highly variable, stating that:

> *"So, I do think your section on Indigenous culture is great. I would just have the question about level of acculturation and then language and religion. You know here in the United States we have different levels of acculturation, even at the Tribal level, where Tribes are*

more in touch with their culture, and their religions, and their language versus others. We're not starting from a level playing field from day one. … we had European colonizers in the East, and then the Spaniards from the Southwest, the Russians from the North in Alaska, so we had various different countries coming in at basically the same time. That earlier contact gave people hundreds of years of learning and cultural exchange and language exchange where the interior Tribes weren't exposed, some of them till 1700, 1800s. That's two or 300 years of a head start with some of the Eastern seaboard. Tailoring programs not only capture and target the health needs of those who are traditional, but also those who may be very much into the more contemporary culture."

A Tribal interviewee also noted variations in cultural practice and knowledge due to historical events.

"The other thing you have to understand is there's a generation gap where particularly in Alaska, where a lot of our youths were put into boarding schools. We're struggling, I think there's two generations there, of trying to relearn language and culture and things like that, just because of people being put at boarding schools and isolated from their families. We lost that bridge, if you will. Relearning the language, the dance and things like that"

5.5.7.2. Spreading Cultural Knowledge

A Tribal participant noted that the establishment of the national Best Practices conferences was an intentional mechanism to allow sharing of knowledge on how Tribes were integrating cultural knowledge and practice with western health care.

"On a national level, what we did, is when we did those national best practices conference, where you really highlight, "This is what we're doing over here in Navajo.", or "This is what we're doing over here in Cherokee." Then, you share what's working and

then people get excited about that. The worst thing you can do is have people continue to work in isolation in their own little worlds and not share it and not communicate with it. Having that dialogue amongst our own people. It's just sharing what works and what doesn't work."

5.5.7.3. Traditional Medicines and Healing

One Tribal participant stated that traditional medicines and healing practices are being revitalized and are an important part of Tribal governance and design of health programs.

"The traditional medicines and healings that I think, Alaska's done an excellent job of looking at the different plants that are used traditionally and the different ways, having traditional healers and respecting them equal to the doctors. That's what makes you unique . . . it can't be token. You say, "Inclusion of elders, wisdom and language." It can't just be token. "Oh. We have an Elders Committee." No. It has to be more than that."

5.5.7.4. Traditional and cultural governing systems should underpin TSG

Another Tribal participant affirmed that culture and identity as Indigenous people was important to maintain authenticity in traditional governance.

"In order to become a recognized government under the Indian Reorganization Act, you had to develop a constitution, bylaws and then a Tribal enrolment ordinance and all that kind of stuff. Well, the United States created a template that they just gave to Tribes and the Tribes filled in the blanks. And . . . it had no bearing on who you were as a Tribal entity in terms of your traditional governing policies. How your religious leaders were organized, like who your political leaders were and stuff. And it took many years for this to manifest itself. The Choctaw people went back to their traditional governing processes, and they changed their Tribal Constitution … and once they did that, there was buy-in

from the masses in the political, the people … because it was representative of who they were before the United States imposed themselves on us as a people."

5.5.7.5. Critique

While this factor emphasizes cultural relevance, Deloria & Lyrtle argue for a deeper integration of cultural integrity within governance structures (Deloria & Lytle, 1998). This means that cultural elements should not be tokenistic but should form the foundation of governance practices.

Duran emphasizes the importance of culturally responsive care in addressing mental health disparities among AI/AN populations (Duran, 2002; Duran & Oetzel, 2005; Duran et al., 1998). They highlight how culturally tailored interventions can help overcome barriers to treatment, such as stigma. This underscores the need for health care systems to integrate cultural competence into their practices, which aligns with the CSF of "Tribal Identity and Culture." While the CSFs emphasize the importance of cultural identity, Duran et al. highlight the need for this to be deeply integrated into health care practices. This means moving beyond symbolic recognition to actual implementation of culturally responsive care models. This is supported by Jernigan et al who emphasize the importance of culturally appropriate interventions to address health disparities in Native American communities (Blue Bird Jernigan et al., 2015; Blue Bird Jernigan et al., 2012; White et al., 2023). Kukutai and Taylor also emphasize that cultural considerations should extend to how data is collected, managed, and used (Kukutai & Taylor, 2016). This challenges the framework to incorporate data governance as a key aspect of cultural identity and self-determination. This means that data should not only be collected with the consent of Indigenous peoples but also managed and utilized in ways that align with their cultural values and priorities.

5.5.8. Sustained communications and inclusion

A Tribal participant affirmed that communication is essential in the world of TSG.

"You've just got to keep communicating constantly. The other part of that communication is you have to have direct communication. The people have to feel like they can go to the top at any time… your leadership has to be accessible to the patient, to the person on the ground. You can't be afraid . . . people cannot feel like they can't go into the office of the Director. That communication has to be pretty transparent and pretty open."

Another Tribal participant supported ongoing communication and keeping leaders informed.

"I support the role that the SGCETC plays to make sure information gets out to Tribal members but also the IHS is disseminating information all the time, including Tribal leader letters, videos and blogs. There is a lot of stuff that each entity sends out. A lot of communicating. Lots of alerts. So, you're constantly informed, now you may not get to read all of it, but the fact is people are trying to inform constantly."

5.5.8.1. Health Literacy is a major issue for AI/AN populations and impacts communication

The NIHB has been advocating for Tribes around the issue of medical literacy for patients, stating that:

"According to the National Assessment of Adult Literacy, only 12 percent of the U.S. population has a proficient health literacy level, and a total of 25 percent of American Indian and Alaska Native respondents scored at a ``below basic'' level. A white paper published by the IHS Health Literacy Workgroup in 2009 stated, ``While low health literacy affects people from all facets of life, it is disproportionately burdensome on vulnerable populations, such as American Indian and Alaska Native people and their elders. Persons with limited health literacy skills make greater use of services designed to treat complications of disease and less use of services designed to prevent complications.' Given the disproportionate levels of low health literacy in AI/AN communities, and its

direct impact on health outcomes and need for care, it is clear that more resources and training are needed within the Indian health system to improve patients' understanding of their own health and health care delivery." (Indian Health Service, 2024; Indian Health Service Health Literacy Workgroup, 2009)

5.5.8.2. The Role of the Self-Governance Communication and Education Tribal Consortium

One of the Tribal participants identified that the role of the SGCETC is essential for self-governing Tribes.

"I think the number one reason for SGCETC was to encourage, it was really to educate Tribes about Self-Governance and to kind of spread the movement. I think that is really still very valuable. And I think it was to make sure that all that information was coordinated and to make sure that Tribes had a place to go so they could be mentored by other Tribes. The fact that you have people who can mentor you through the process and you can talk to about their experience and who can come and talk to your Tribal Council about what this means I think is really very, very helpful. So, it really is a multi-faceted effort. SGCETC hub of all the information, to hold the conferences, to hold the meetings, and to do that work too. It is an essential piece. Somebody needs to be the coordinator because Tribal leaders are really busy. No one Tribal leader is going to take that work on or their staff, right? And you kind of want this, you kind of want Switzerland there."

Another Tribal interviewee confirmed the important role of the SGCETC in maintaining communications between Tribes and with the Federal government.

"The SGCETC has different mechanisms for staying in touch. And you'll see on those calls and those advisory meetings that every decision made isn't to the benefit to every single Tribe. But they formed those relationships and understand that, yeah, this is probably for

the best of the majority of Tribes. And so, I'll still support it because it's for the best of Indian country, even though it's not in my best interest. And that definitely takes time and trust and decades of those relationships being built for that to be the approach. So, those first 10 Tribes that were involved with the demonstration pilots, they formed a bond … I think they were like, if we're going to have this for the long term, we really need to have an institution and somewhere established, that can serve as the repository of information. And it can be kind of that central point to bring us all together … so, they had actually worked with Congress and got funding dedicated to SGCETC for its creation. SGCETC is not a lobbying arm like the NIHB. It's a resource to help Tribes for capacity building, for sharing information, for sharing knowledge. NIHB, they also do that, but they're also very heavily focused on a lobbying front."

The SGCETC identified that communications have been very challenging as explained by one Tribal participant:

"I think that right now our direct email, so the email blasts through our listserv, is by far the quickest and most effective mechanism for communicating, particularly with Tribal leaders that are extremely busy, have lots and lots of things going on. We can use that direct email to send high urgency type messages, which can get their attention. We've tried with the website, we've tried putting announcements and updates on there, but to be honest, we've done a number of different analyses on users of the website and visits. And it's not utilized. So, if you really want to get people's attention, we have to send them a direct email blast. We've also just recently released a community forum which is password protected. And it is a Tribal only website."

5.5.8.3. Tribal Consultation is a Key Factor in Communication

A Federal interviewee stated that Tribal consultation and communication is a key function for the IHS.

> *"Turning to the issue of consultation … it is a requirement for IHS and the Department of Interior. A provision in the law specifically states that the Secretaries of the Interior as well as Health and Human Services shall consult annually with Tribes and Tribal organizations, soliciting participation on the annual budget and preparing a budget request for Congress. Executive agencies have developed policies on how to implement consultation. HHS and IHS define consultation as a form of communication that emphasizes trust, respect and shared responsibilities with Tribes and Tribal organizations."*

Evidence shows however that even with Tribal consultation policies being in place, there is a need for Tribes to constantly monitor Federal agencies to ensure they are implementing those policies. This challenge was identified in a guest editorial by two Tribal health leaders from USET (Malerba, 2016) when they stated:

> *"While the U.S. has not returned to a practice of seeking the consent of Tribal nations, the developing Tribal consultation process begins to recognize our inherent rights and authorities when it comes to federal decisions that impact our citizens and homelands. Over the last eight years, federal agencies have been required to develop and implement Tribal consultation policies in collaboration with Tribal nations. Tribal nations continue to experience inconsistencies in consultation policies, the violation of consultation policies, and mere notification of federal action as opposed to a solicitation of input. Time and again, Tribal nations have expressed a desire for consultation to be more meaningful. The U.S. must move beyond an approach that merely "checks the box" of consultation. It*

is time for a Tribal nation defined model, with dual consent as the basis for strong and respectful diplomatic relations between two equally sovereign nations. In the long term, we must return to a model of Tribal nation consent for federal action as a recognition of sovereign equality and as set out by the principles of the United Nations Declaration on the Rights of Indigenous Peoples."

5.5.8.4. Critique

The NCAI developed a guideline for communicating with Tribes, available through their website (National Congress of American Indians, nd-a). One of the key guides in the documents relates to Native Americans having "*a long and varied history of storytelling and culturally unique ways of communicating with one another and with other communities*". This history of storytelling has not been identified within this CSF as a necessary cultural element to maintaining sustained communications. The guideline suggests that when communicating across cultural lines (whether that is between Tribes or to non-Native communities), communicators should seek to incorporate this rich tradition of storytelling and oral histories into key messaging. A key quote in the guideline also provides advice around this aspect:

"How effectively we communicate depends on how well we adapt our long history of storytelling into persuasive messages that move the people we need to move. We must deliver strong and compelling messages consistently if we expect to have an impact on the issues we care about." (National Congress of American Indians, nd-a)

Embedding these cultural traditions into communications should also reflect how messages are delivered, especially in meetings. The NCAI guideline notes that "Native people are quite accustomed to lengthy introductions that include family relations and histories, identifying one's clan and Indian name, and offering greetings, prayers and often songs in Native languages. In some

circumstances, many become offended if this protocol is not followed. Or, at the very least, a speaker who doesn't adhere to these communication mores is viewed as an outsider". This challenges the current description of this CSF and suggests further work is needed to reflect cultural aspects of communications.

5.5.9. Accountability for all

5.5.9.1. Accountability to Tribal Citizens in a Self-Governance Model

A Tribal interviewee affirmed that accountability, Self-Governance and self-determination are all linked.

> *"I really think that kind of is one of the important characteristics too. I think as long as the Federal government runs programs, there's no accountability at all … but when a Tribe takes over accountability, if there's a Tribal member that's not satisfied that they can get an appointment at the clinic, or they've had a bad experience at the clinic. I know as soon as they get home, they're probably calling the Tribal Chairman … where else in the United States or in the world for that we have that kind of accountability."*

In terms of accountability to the Federal government, another Tribal participant stated:

> *"So, there's different layers of accountability when Self-Governance and self-determination comes about that you may not necessarily have under the status quo. Federal government reporting is so high level, they're so distant from the ground to the top."*

5.5.9.2. Accountability of the Indian Health Service

In 2016 – 2017, the NIHB gave testimony for a bill bring introduced to improve accountability at the Indian Health Service – the Restoring Accountability in the Indian Health

Service Act 2016 (S.1250) (Board, 2016). The bill proposed amendments to the Indian Health Care Improvement Act to require the Department of Health and Human Services (HHS) to establish systems for health care professionals employed by Indian Health Service (IHS) in relation to salaries, credentialling, standards, liability, expansion of the Loan Repayment program to include health administration, and training. The bill also planned to establish: (Senate Hearing 110-450) whistle blower protections for IHS employees, and (2) requirements concerning IHS fiscal accountability and transparency.

The NIHB submitted that the proposed legislation was attempting to address long-standing Tribal concerns and the move forward to improve the overall accountability and transparency of IHS. It is admirable and appreciated and necessary for staff. The spirit and intent of this legislation is clearly aimed at responding to the call of Tribal leaders, patients, and families like all of those we heard yesterday and that we've heard down through the decades. We believe that structure reform of the agency is needed. There are unique challenges to delivering health care in any rural setting in the United States. These include provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. The bill, of course, mandates the Secretary of HHS to report each quarter of the fiscal year describing expenditures, outlays, transfers, programming obligations, and other spending at each level of the service to Congress, Tribes and the IHS. It does not have substantive measures in place to ensure that the mismanagement of these resources does not continue.

5.6. Comparison of the overall framework against other Self-Governance models

As well as the member validation, a review of literature on other examples of Indigenous Self-Governance model was undertaken, to determine if there was alignment with those models.

5.6.1. An Indigenous Australian model

Researchers from the Indigenous Community Governance Project (ICGP) at the Australian National University (Hunt & Smith, 2007) conducted extensive research in Indigenous Aboriginal communities in Australia in 2006, resulting in a number of research papers. Their 2007 paper identified findings and issues related to the complexity of Aboriginal communities and leadership; networked governance; cultural legitimacy; governance capacity development and the governance capacity of governments. Further information is provided below.

5.6.1.1. Networked governance

Hunt and Smith identify (Hunt & Smith, 2007) that "leadership in Indigenous communities consists of nodes of influential individuals who are connected through networks that have been formed out of relationships, and their shared histories, values, experience and knowledge." This privileges their interconnectivity and supports networked governance. Key Indigenous design principles for governance included for instance networked governance recognizes local groups and communities with their own roles, authorities and responsibilities – and supports capacity development at all levels, not just at the top and decision-making responsibility is located at the closest possible point of connection to the people affected, while decision-making at higher levels for more inclusive matters requires subsidiarity.

Subsidiarity is a concept introduced in the research and describes the notion that the component parts of the network must have effective control over their spheres of action. For instance, centralized governance should undertake initiatives that exceed the capacities of individuals or communities acting independently, and no higher centralized unit should undertake functions that can be effectively done at a local level. This finding by the Australian researchers aligns well with one of my critical success factors – unified Tribal leadership – as both discussions center around networked governance arrangements.

5.6.1.2. Cultural Legitimacy

Hunt and Smith identify that legitimate Indigenous governance arrangements win the support of members and external stakeholders and produce outcomes (Hunt & Smith, 2007). Such legitimate governance arrangements reflect contemporary Indigenous views of what are proper relationships, forms of authority and cultural geographies, but they also simultaneously display practical management and service capacity to deliver outcomes. Sustaining legitimacy requires organizations to meet the reporting accountabilities to external stakeholders, while also looking after, and working for the people. This concept aligns well with two of my critical success factors: the first being "political will" of the people for their leadership, and of Congress to support Self-Governance goals of Tribes. The second relates to "accountability for all" – as leadership must maintain its accountability to the people who elected them to power, if they are to sustain that support, while also maintaining accountability to partners and Government.

5.6.1.3. Governance capacity development

Hunt and Smith note "Indigenous skills, abilities, knowledge and leadership are most effectively mobilized and exercised when initiatives are Indigenous-driven, towards Indigenous goals." (Hunt & Smith, 2007). Furthermore, they highlight that governance capacity is greatly strengthened when "Indigenous people create their own rules, policies, guidelines, procedures, coeds, etc. and design the local mechanisms to enforce those rules." This is the essence of Self-Governance – when Tribes can make and enforce their own rules. The research findings reveal that Indigenous governance is successful at doing this when they are pre-emptive of environmental changes and circumstances and able to respond quickly and decisively. Hunt and Smith recommended a nation-wide human resource strategy be developed to build the Indigenous workforce needed for community and regional governance, and training that is targeted, high

quality and place-based. They state that governance capacity development is needed for leaders, managers and staff at all levels (Hunt & Smith, 2007).

This focus on workforce development in governance is also one of my critical success factors – qualified workforce – which also has a focus on building the capability and capacity of the Indigenous workforce at all levels across a self-governing system.

5.6.1.4. Effective Governance Impacts Economic and Social Outcomes

The research conducted by Hunt and Smith has a set of 10 key messages from the research team (Hunt & Smith, 2007). Much of the discussion above is included in these key messages, however two other lessons can be learned from their work. The first relates to the impact of strong Indigenous governance on socioeconomic development and social outcomes. They note that economic development works best when effective Indigenous governance capacity and non-Indigenous governance capacity co-exists. Furthermore education, financial literacy and health status appear to be critical factors in achieving effective governance for economic development. Hunt and Smith state that where there is strong visionary leadership; strong culturally-based institutions of governance; sound, stable management and professional support staff; strategic networking with public and private sector partners; infrastructure substantially in place; access to training and mentoring opportunities; and frequent planning and review – economic and social indicators are better (Hunt & Smith, 2007).

The success factors outlined by the researchers as positively impacting on economic and social outcomes, align quite specifically to my CSF framework since they cover the elements of strong unified leadership, important partnerships and qualified workforce.

One area not specifically covered within the research, is the data and information needed or used by Indigenous governance and by government, to monitor what is happening with achievement of economic and social goals. While there is light mention of the need to review progress, the

researchers did not identify data and information as critical for effective Indigenous governance as I have identified. I still maintain that a focus on data (qualitative and quantitative) is necessary for effective Self-Governance and that setting a baseline at the time of adopting Self-Governance arrangements (along with goals and indicators) is important to track progress over time.

5.6.2. Indigenous Canadian models

5.6.2.1. Attributes of Indigenous governance

D. Smith describes in his paper (D. Smith, 2005) a number of examples of "strong Indigenous governance." He notes that in a presentation to an Indigenous governance conference, Sterritt, a Gitxsan leader from Canada, characterized strong Indigenous governance as having four main attributes or dimensions (Sterritt, 2002):

- **legitimacy**: the way structures of governance are created, and leaders chosen, and the extent of the constituents' confidence in and support of them
- **power**: the extent of acknowledged legal, jurisdictional and cultural authority and capacity to make and exercise laws, resolve disputes and carry-on public administration
- **resources**: the economic, cultural, human, technological and natural resources needed for the establishment and implementation of governance structures, and;
- **accountability**: the extent to which those in power must justify, substantiate and make known their actions and decisions.

Evidence presented by Sterritt, on the Report of the Royal Commission on Aboriginal Peoples submitted in 1996 (Government of Canada, 2016) suggests that these four attributes are expressed through First Nations institutions and processes such as the centrality of land, individual autonomy and shared responsibility, the role of women and elders, the role of family and clan, leadership and traditional accountability, and consensus in decision-making.

5.6.2.2. Attributes for strong Indigenous governance

Another suggestion on key attributes for strong Indigenous governance come from Harvard University (Cornell, 1993) who identified a similar set of prerequisites as Sterritt including de facto sovereignty or self-rule: genuine decision-making power where the Tribal government effectively held the reins of power over strategic decisions, the allocation of resources and related governing processes; effective governing institutions: groups must have the non-partisan representation; dispute resolutions mechanisms; rules for constraining corruption; and capable bureaucracies; and cultural match: legitimate in the eyes of those they serve. They must wield power and authority in conformity with Indigenous conceptions, beliefs and agreed rules.

5.6.2.3. Five pillars of effective First Nations governance

The Centre for First Nations Governance (CFNG) describe five pillars of effective governance (The Centre for First Nations Governance, n.d.):

(1) **The People**: ensuring citizens develop a shared vision and priorities; that they participate in decision-making to gain a clear mandate and strategic direction from the people, and sharing information with the people (meaningful information sharing)

(2) **The Land**: capturing and documenting historic and present-day connections to territory including historic laws, creation stories, oral histories, language, culture, tradition and spirituality. Rebuilding a sustainable economy on the land through the inherent and legal right to fully benefit from their title and treaty lands and asserting inherent responsibility to protect and preserve the land.

(3) **Laws & Jurisdiction**: Exercising authority and sovereignty, within the limits of the law and expanding jurisdiction in a variety of ways (e.g. accepting offers of delegated authority, negotiating increased jurisdiction, or by exercising the inherent right of Self-Governance). Many Nations can also develop enforceable laws over territories.

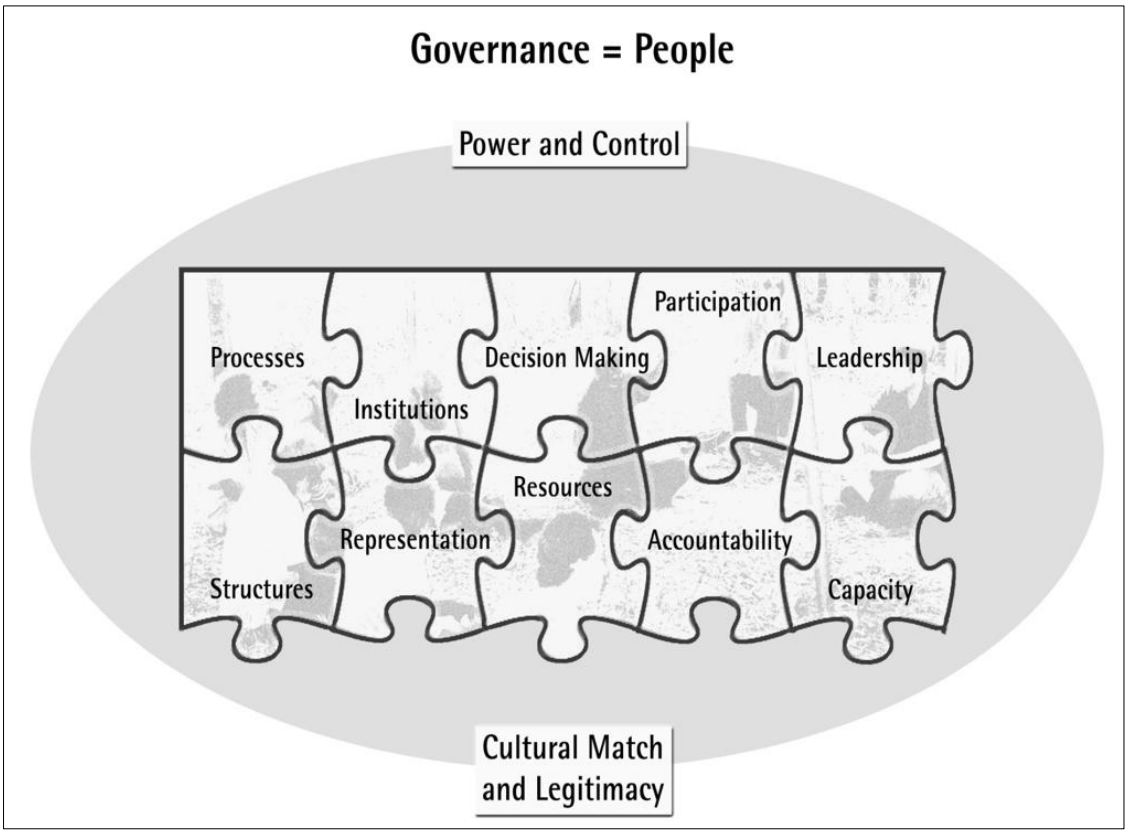
(4) **Governing Systems**: Designing governing systems and services that are transparent and fair. Transparency through direct participation reduces the chance for preferential treatment and the dominance of private or personal interests over the interests of citizens. Focusing on results-based governance by tracking results and reporting on findings. Developing governing systems based on people's traditions, principles, values and vision. Cultural alignment anchors a nation's governance to its own unique traditional systems founded on the people's history, culture, traditions, values and vision. Developing productive working relationships with other governments.

(5) **Resources**: Investing in the development of current and emerging leaders and managers. Planning finances with future generations in mind since financial management ability allows for multi-year planning and proactive decision-making. Evaluating performance, recognizing success and reporting results to the community. Developing thorough, transparent systems of accountability and reporting. Diversifying revenue sources to fund self-government.

5.6.3. Concepts of governance

D. Smith includes a diagram (Figure 39 below) summarizing the concepts of governance from his research (Hunt & Smith, 2007; D. Smith, 2005):

Figure 13: The Concept of Governance



Similarities between my original framework and that proposed by Smith are compared in the table below.

Table 3: Comparisons of my CSF Framework with other Indigenous governance frameworks

MY CSF FRAMEWORK	SMITH'S "CONCEPT OF GOVERNANCE"	CENTRE FOR FIRST NATIONS GOVERNANCE
POLICY AND POLITICAL WILL (OF CITIZENS, TRIBE AND GOVERNMENT)	Representation	Law and Jurisdiction (exercising sovereignty and authority)
SUCCESSFUL PARTNERING	-	Governing systems (developing working relationships with other governments)

MY CSF FRAMEWORK	SMITH'S "CONCEPT OF GOVERNANCE"	CENTRE FOR FIRST NATIONS GOVERNANCE
ACCOUNTABILITY FOR ALL	Accountability	Resources (United States Government Accountability Office Report to the Chairman Committee on Indian Affairs)
UNIFIED TRIBAL LEADERSHIP	Institutions Structures Leadership	People (shared vision)
QUALIFIED WORKFORCE	Capacity	Resources (people development)
SUSTAINED COMMUNICATIONS & INCLUSION	Participation	People (Information sharing and communications)
INFUSION OF INDIGENOUS CULTURE	Cultural Match & Legitimacy	Land (capturing history, language, culture, traditions)
FLEXIBLE FUNDING AND REVENUE SOURCES	Resources	Resources (revenue sources, management of resources)
ROBUST DATA AND MEASUREMENT	Accountability	Governing systems (tracking results and reporting, accountability)

5.7. Critical analysis of the overall CSF framework

Professor Bryan Brayboy affiliates to the Lumbee people of Carolina, and in 2005 he introduced Tribal Critical Race Theory (TribalCrit) (Brayboy, 2005) which offers a framework specifically designed to address the unique experiences and perspectives of American Indians, primarily in educational contexts. This framework can provide insights that challenge or offer alternative perspectives to the Critical Success Factors (CSFs) for Tribal Self-Governance. The following is a critical analysis based on Brayboy's TribalCrit.

TribalCrit is a branch of Critical Race Theory (CRT) tailored to the experiences of American Indians (Bartlett & Brayboy, 2005; Brayboy et al., 2008; Brayboy & Deyhle, 2000;

Brayboy, 2004, 2005; B. M. J Brayboy, 2021; Brayboy & Castagno, 2009; Brayboy, Gough, et al., 2012; Brayboy & Maughan, 2009; Castagno & Brayboy, 2008; McKinley, 2018). It emphasizes the importance of understanding Indigenous experiences through their historical, cultural, and political contexts. Brayboy outlines several tenets but key ones relevant to Tribal Self-Governance include:

- Colonisation as Endemic: Recognizes that colonisation is a pervasive force in society, influencing policies and institutions.
- Imperialism and White Supremacy: Critiques U.S. policies toward Indigenous peoples as rooted in imperialism and material gain.
- Liminal Space: Acknowledges the dual political and racial identities of Indigenous peoples creates a liminal space to be navigated.
- Cultural, Knowledge, and Power Dynamics: Emphasizes the need to view these concepts through an Indigenous lens.

Critical analysis of the CSFs through the TribalCrit lens reveal the following:

- *Tribal Unity and a Shared Vision*: While unity is important, TribalCrit suggests that imposed unity can ignore the diverse cultural and political contexts of different Tribes. It highlights the need for governance structures that respect and integrate these unique identities rather than enforcing a homogenized vision.
- *Tribal Identity and Culture*: TribalCrit supports the emphasis on cultural relevance but warns against tokenistic inclusion. It stresses that governance should genuinely reflect Indigenous knowledge systems and power dynamics, ensuring that cultural practices are not merely symbolic but integral to decision-making.
- *Policy and Political Will*: TribalCrit challenges the reliance on federal policies, which may perpetuate colonial power structures. It advocates for policies that are

developed from within the community, reflecting Indigenous values and priorities rather than external impositions.

- *Workforce Capability and Development*: The focus on workforce development should include cultural competence and the integration of Indigenous knowledge. TribalCrit emphasizes that education and training should empower Indigenous peoples to navigate and transform existing systems.
- *Equitable Funding and Revenue*: While equitable funding is crucial, TribalCrit argues for a broader approach that addresses systemic inequities and supports Indigenous economic sovereignty. This includes recognizing and dismantling the colonial legacies in funding mechanisms.
- *Accountability for All*: TribalCrit suggests that accountability frameworks should be culturally resonant and community-driven. External accountability measures should not undermine traditional governance practices.
- *Successful Partnering*: Partnerships should be equitable and respectful of Indigenous sovereignty. TribalCrit highlights the risks of partnerships that reinforce power imbalances or prioritize non-Indigenous agendas.
- *Sustained Multimedia, Multi-level Communication*: Communication strategies should be inclusive and culturally appropriate, ensuring they reach all community members and respect Indigenous communication practices.
- *Robust Technology, Information, and Data*: TribalCrit Emphasizes the importance of data sovereignty and the need for Indigenous control over data collection, analysis, and use. This aligns with the broader movement for Indigenous data governance.

Brayboy's TribalCrit provides a critical lens through which to evaluate and potentially enhance the CSFs for Tribal Self-Governance. It underscores the importance of culturally matched governance structures and policies that genuinely reflect Indigenous values and priorities. By

incorporating these perspectives, the framework can better support the self-determination and sovereignty of Tribal communities.

Kalt and colleagues' research (Cornell & Kalt, 2010) provides a nuanced perspective that highlights the importance of cultural alignment and self-determination in governance structures. While the framework for Tribal Self-Governance includes valuable elements, it may benefit from incorporating more flexibility to accommodate the diverse cultural and political landscapes of different Tribes. This would ensure that governance structures are not only effective but also culturally resonant and supported by the communities they serve.

Esteemed Sioux scholar Professor Vine Deloria Jr. and political scientist Professor Clifford M. Lytle's work in the 1980s and 1990s (Deloria, 1983, 2004), particularly in their book "The Nations Within: The Past and Future of American Indian Sovereignty," (Deloria & Lytle, 1998) provides a critical perspective on the governance and sovereignty of Native American Tribes. Their analysis offers insights that can challenge or provide alternative viewpoints to the Critical Success Factors (CSFs) for Tribal Self-Governance:

- Sovereignty and Self-Determination: Deloria and Lytle emphasize the importance of sovereignty and self-determination for Native American Tribes. They argue that true Self-Governance requires Tribes to have control over their own affairs without undue interference from federal or state governments. This perspective challenges any governance framework that relies heavily on external policies or political will, as it can undermine Tribal sovereignty.
- Critique of Federal Policies: Their work critiques the historical and ongoing impact of federal policies on Tribal governance. Deloria and Lytle highlight how these policies often perpetuate dependency and limit the ability of Tribes to exercise true Self-Governance. This critique aligns with concerns about the reliance on federal

policies and political will as a critical success factor, suggesting the need for more autonomous Tribal policies.

- Cultural Integrity: Deloria and Lytle stress the importance of maintaining cultural integrity and identity within governance structures. They argue that governance models should be rooted in the cultural and historical contexts of each Tribe, rather than being imposed or influenced by external forces. This supports the emphasis on Tribal Identity and Culture within several CSFs but also warns against superficial integration of cultural elements.
- Challenges of Imposed Unity: The authors caution against imposed unity among Tribes, which can ignore the diverse needs and aspirations of different communities. They advocate for governance structures that respect the unique identities and self-determination of each Tribe, rather than enforcing a homogenized approach. This challenges the notion of Tribal Unity and a Shared Vision if it does not arise organically from the Tribes themselves.

Deloria and Lytle's work provides a critical perspective that underscores the importance of sovereignty, cultural integrity, and self-determination in Tribal governance. Their insights challenge aspects of the CSFs that rely on external influences or impose uniformity across diverse Tribes. By incorporating these perspectives, the framework for Tribal Self-Governance can better support the unique identities and aspirations of each Tribe, fostering true self-determination and autonomy.

Studies by native American physician Dr TomSequist and colleagues (Sequist, 2021; Sequist, Cullen, & Acton, 2011; Sequist et al., 2005; Sequist, Cullen, Bernard, et al., 2011) explore challenges within the Indian Health Service (IHS) related to cultural competence and health care delivery to Native American communities. Eduardo Duran, his partner Bonnie Duran, and Colleagues (Duran, 2002; Duran & Oetzel, 2005; Duran et al., 1998) all provide valuable insights into the importance of cultural competence in health care delivery to Native American communities.

They provide valuable insights into the importance of culturally responsive care and community-level interventions for AI/AN populations. Their research challenges the CSFs for Tribal Self-Governance to ensure that cultural considerations are deeply integrated into health care practices and governance structures. By addressing these challenges, the framework can better support the health and well-being of Native American communities through culturally competent and accessible health care services.

The study by Indigenous health researcher Dr Donald Warne and Cherokk and Lakota scholar Dr Linda Bane Frizzell (D. Warne & L. B. Frizzell, 2014) provides a comprehensive overview of the historical and contemporary issues in American Indian health policy, including the impacts of the Patient Protection and Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). Warne and Frizzell provide valuable insights into the complexities of American Indian health policy and the challenges faced by Tribal health systems. Their research highlights the need for systemic reforms and culturally competent care, challenging the CSFs to incorporate these elements more deeply into the framework for Tribal Self-Governance. By addressing these challenges, the framework can better support the health and well-being of Native American communities through policies and practices that are both equitable and culturally resonant.

Emeritus Professor of Sociology Stephen Cornell and Professor Koseph P. Kalt's work (Cornell & Kalt, 2010), particularly their research on American Indian self-determination and governance, also provides a foundational perspective on the importance of culturally matched governance structures and the role of sovereignty in economic and political development. Studies by Professor Valerie Blue Bird Jernigan and colleagues (Blue Bird Jernigan et al., 2015; Blue Bird Jernigan et al., 2012) also focus on health disparities and culturally appropriate interventions for Native American communities. They provide valuable insights into the importance of culturally appropriate interventions and community engagement for Native American communities. These

researchers challenge the CSFs for Tribal Self-Governance to ensure that cultural considerations are deeply integrated into health care practices and governance structures, but are also culturally resonant and empowering.

Māori scholar Professor Tahu Kukutai and Austalian scholar Professor John Taylor's work on Indigenous Data Sovereignty (IDS), particularly their 2016 publication (Kukutai & Taylor, 2016) provides a comprehensive framework for understanding and implementing data governance that respects the rights and sovereignty of Indigenous peoples. Their research challenges the CSFs for Tribal Self-Governance to incorporate data sovereignty as a fundamental component, ensuring that data practices are aligned with Indigenous values and controlled by Indigenous communities. By addressing these challenges, the framework can better support the unique identities and aspirations of Indigenous peoples, fostering true self-determination and autonomy.

Summary critique

Viewed through a Critical Tribal lens, this framework, while addressing important aspects of Tribal Self-Governance in health care, may not sufficiently challenge the underlying colonial structures and power imbalances that continue to impact Indigenous health. The framework risks perpetuating a Western, bureaucratic approach to health care governance rather than truly centering Indigenous ways of knowing and healing.

A more comprehensive approach informed by Critical Tribal Theory would emphasize decolonization, restoration of Tribal sovereignty, revitalization of traditional healing practices, and addressing the broader social and environmental determinants of Indigenous health that stem from historical and ongoing colonialism (Isaac, 2018; Wilson et al., 2023). A summary of the CSF framework critique is shown in the table below:

Table 4. Critique of Framework against Critical Tribal Theory

STRENGTHS OF THE FRAMEWORK	CHALLENGES AND CRITICISMS	CRITICAL TRIBAL THEORY
Cultural Relevance: The framework emphasizes the importance of Tribal identity and culture, ensuring that governance aligns with the unique traditions and values of each Tribe. This cultural match is crucial for gaining the support of Tribal citizens and fostering a sense of ownership and empowerment. **Comprehensive Scope**: By addressing various aspects such as policy, workforce development, funding, accountability, and technology, the framework provides a more holistic approach to improving Tribal health governance. This approach ensures that multiple dimensions of governance are considered, which can lead to more sustainable and effective outcomes. **Focus on Partnerships**: The inclusion of successful partnering as a critical factor highlights the importance of collaboration between Tribes,	**Diverse Tribal Needs**: The diversity among Tribes in terms of culture, size, and socio-economic conditions presents a challenge to the framework's applicability across all Tribes. A one-size-fits-all approach may not adequately address the specific needs and priorities of each Tribe. **Data and Evaluation Limitations**: There is a noted lack of comprehensive data and evaluation mechanisms to assess the effectiveness of Tribal Self-Governance. This makes it difficult to measure outcomes, identify best practices, and make informed decisions about governance improvements. **Potential for Dependency**: While the framework Emphasizes Self-Governance, reliance on federal policies and funding can perpetuate dependency, potentially undermining true autonomy and self-determination. This highlights the need for Tribes to develop independent revenue streams and governance structures.	**Empowerment of Local Governance Structures**: While empowering local Tribal governance is important, this factor fails to fully acknowledge the historical context of colonization and forced relocation that disrupted traditional governance systems. Critical Tribal Theory would emphasize the need to revitalize and restore traditional Indigenous governance models rather than simply empowering existing structures that may have been imposed or influenced by colonial systems (Wilson et al., 2023). **Cultural Relevance and Integration**: Integrating cultural practices into health care is crucial, but this factor risks essentializing Indigenous cultures or treating them as static. A Critical Tribal perspective would emphasize the dynamic nature of Indigenous cultures and the need for health care systems that can adapt to evolving cultural practices and beliefs (Isaac et al., 2018). **Community Engagement and Participation**: While community engagement is vital, this factor may not adequately address power imbalances between Tribal communities and external health care systems. Critical Tribal Theory would call for true community control and decision-making power, not just participation in externally-driven processes (Wilson et al., 2023).

STRENGTHS OF THE FRAMEWORK	CHALLENGES AND CRITICISMS	CRITICAL TRIBAL THEORY
government agencies, and other stakeholders. This can enhance resource sharing, knowledge exchange, and the overall effectiveness of health services. **Adaptability and Flexibility**: The framework's emphasis on equitable funding and the ability to generate additional revenue allows Tribes to tailor their financial strategies to meet their specific needs. This flexibility can be transformative in addressing the unique challenges faced by different Tribes in the U.S.	**Complexity of Implementation**: Implementing the framework requires significant capacity in terms of leadership, workforce development, and technology infrastructure. Tribes may face challenges in building this capacity, especially those with limited resources or experience in managing complex health systems. **Balancing Traditional and Modern Practices**: The integration of traditional governance models with modern health care practices can be challenging. There may be conflicts between preserving cultural practices and adopting new technologies or methodologies that are necessary for effective health governance.	**Capacity Building and Skill Development**: Capacity building is important, but this factor could perpetuate deficit-based approaches if not carefully implemented. A Critical Tribal lens would emphasize building on existing strengths and knowledge within Tribal communities rather than assuming a lack of capacity (Isaac et al., 2018). **Sustainable Funding and Resources**: While sustainable funding is crucial, this factor does not address the historical and ongoing economic exploitation of Tribal lands and resources. Critical Tribal Theory would call for reparations and restoration of Tribal economic sovereignty as part of ensuring sustainable resources (Wilson et al., 2023). **Data Sovereignty and Information Systems**: This factor is important but may not go far enough in addressing the history of research exploitation in Indigenous communities. A Critical Tribal approach would emphasize full Tribal ownership and control of data, as well as Indigenous-led research methodologies (Isaac et al., 2018). **Partnerships and Collaboration**: While partnerships can be valuable, this factor risks perpetuating unequal power dynamics between Tribes and external entities. Critical Tribal Theory would emphasize nation-to-nation relationships and Tribal sovereignty in any collaborative efforts (Wilson et al., 2023).

5.8. Chapter summary

This chapter focused on the validation process of the draft critical success factor framework for effective TSG, the hypothesis of this research. The validation process included Member information as well as references to other documents, submissions, policies and processes that affirmed the nine factors as being critical to the success of TSG. However, the critical analysis of the factors and the overall framework has identified areas that should be added to the updated framework, and challenges that users of the framework need to be aware of.

The key informants supported the nine factors and provided many examples from their own experiences on why the factor was important and its impact on TSG. Many of the members also pointed out the risks and challenges with each CSF, and some of the strategies used to overcome those obstacles. For many, some of the work on the factors is still ongoing and a 'work-in-progress'.

A key finding from the validation process was in relation to the relative importance of each CSF and sequencing. The feedback, validation and critique of the factors and the overall framework are used in the following chapter to describe and make improvements to the draft CSF framework.

CHAPTER 6: UPDATING THE CSF FRAMEWORK

6.1. Findings from the Validation Process

The validation process overwhelmingly affirmed the nine factors as being critical to the success of TSG. All of the key informants supported the nine factors and could relate to each of them and provide further rationale as to why they were important. When looking at my one-page schematic, all of them agreed this represented the important features of Tribal Self-Governance. However, several were confused by the inter-relationship of the factors and how these were presented in the diagram. They recommended that it be updated to provide more clarity and to emphasize the most essential elements and provide some ranking.

6.1.1. Adaptation of the CSF Framework following validation

Based on the findings of the validation process, there emerged a need for changes to some of the CSFs to improve their clarity and purpose, as well as the critical content descriptions (summarized on page 2 of the original CSF framework):

- '**Unified Tribal Leadership**' needed to be amended to 'Tribal Unity and a Shared Vision.' The shared vision will be the glue to keep Tribes united – but if leaders are not on the same page and do not want the same things collectively and individually – then working together harmoniously will be a challenge. In relation to all other factors, this particular factor needs to be elevated in importance to the top. It was the factor most discussed by the key informants and additionally further evidence (since 2018 when I developed the original framework visual) continues to show the benefits of leaders working together to advocate for important matters. This was certainly evident during the Senate Committee hearing for the review of TSG after 30 years, held in 2018.

- '**Infusion of Culture**' is another label requiring greater clarity. It is important to informants that culture is infused across the Tribal health system, but it is more important that the unique identity and culture of the Tribe is prominent, respected and used as the basis for ensuring the governing role aligns with what Tribal citizens want from their leaders. Traditional governance models need to be encouraged as was evidenced in the critical analysis. This need for the 'cultural match' alluded to by Cornell et al. was also a strong theme – as citizens need to support their Tribal leaders and the governing institutions that represent them, in order to be strong. If leaders represent their Tribes without the backing of their citizens, they walk a slippery slope. The governing institutions need to be a good fit with the identity, culture, land and traditions of the Tribe to get this kind of citizen mandate. This is because individual Tribal leaders need to know, understand and believe in the vision of their own citizens and Nation first, before they can take that vision to a wider table with other Tribal leaders. When those individual visions and aspirations align – so too will Tribal leadership. This label will be amended to 'Tribal Identity and Culture.'
- '**Policy and Political Will**' remains a valid label for this success factor and much of the validation evidence affirms this. The supporting explanation however needs to be very clear that this applies to the policies (including laws) and political will of Federal [and state] government, as well as the policies [and laws] and political will of Tribal leadership as well. Of all factors, this one requires reciprocity on both sides. Without the right policy and political environment on both the Federal and Tribal side, the ability for leaders to come together to advance this cause is fraught with difficulty, if not, an impossibility.
- '**Qualified Workforce**' was absolutely validated as a critical factor however I amended this label to 'Workforce Capability and Development' because the word 'qualified'

infers that it is relevant only to those with formal qualifications. It was very evident however that it was more important to have capable leaders, administrators, and health practitioners, who are continually supported to learn and develop in both formal and informal settings. Unless Tribal and health leaders are well-informed and educated about the system's issues among other matters such as legal options, they are not in the best position to represent and advocate strongly for the Tribe. They need sound technical and legal advice; they need to be appraised of external environmental and political issues; and they need to have confidence that when they appear on a matter, they know what they are talking about. This factor focuses on ensuring the leaders have the capability and support they need to both communicate and share the vision, but also to articulate the need for removal of any barriers that may impede achievement of that vision.

- '**Flexible Funding and Revenue**' has been amended to 'Equitable Funding and Revenue' following the validation process. This is because TSG arrangements already offer flexibility. The main challenge for current TSG arrangements is that the resources are not equitable, especially with other health systems (e.g., Prison Health or Veterans Affairs). Financial resources are also not equitably deployed to Tribes within the DHHS ring-fence. The revenue element is affirmed to acknowledge the opportunities for Tribes (created by the Affordable Care Act 2010) to bill third parties to generate more revenue. But also, to attract revenues from grants, co-investors and the private sector. For many Tribes the ability to bill above and beyond the IHS funding has been very transformational. Tribes in a TSG arrangement must have the ability to receive their fair share of funds, but also to generate more if they can without barriers preventing them from doing so. This is especially so in the severely underfunded current environment of TSG.

- '**Accountability for All**' – this factor was affirmed as important and remains essential to apply to all levels and all stakeholders in the TSG setting. That includes accountability first and foremost to citizens – but also to Tribal Leaders, to government (for contractual arrangements), to the public via Congress and to partners. As a result, this label will remain as is, since it encompasses all stakeholders.

- '**Successful Partnering**' – this factor was affirmed as important and evidenced by stories of several different partnership arrangements, some formal and some informal. These exist between Tribes locally, regionally and nationally; between Tribes and the IHS; between Tribes and other branches and Departments; between Governments / Tribes and other corporate, community and academic institutions. Like the label before it, this label is therefore broad enough to encompass all types of relationships. There is also a need to ensure the processes of partnership and relationships are culturally relevant and respectful.

- '**Sustained Communications and Inclusion**' has been amended to 'Sustained multi-media, multi-level communication'. Sustained communication has been affirmed as a critically essential feature of the TSG environment, ably led by the SGCETC as well as the NCAI and NIHB at a national level. However regionally and locally many other institutions and Tribal partners offer all forms of communications, using many different forms of media. Given Tribal unity and successful partnering infer a dimension of inclusion already, it makes sense that communication is highlighted specifically but with an emphasis on using multiple methods and reaching all of the layers of the health system. The new label is intended to achieve this. In addition the importance of traditional methods of communication such as storytelling need to be incorporated and respected.

- '**Robust data and measurement**' has undergone an update to reflect the need for appropriate technology to support data and measurement. The new label is 'Robust technology, information and data'. Removing measurement does not imply that performance measurement is not necessary. However, using technology, information and data is not just for performance measurement purposes. It is also used for quality improvement reasons, for advocacy, for accountability requirements and for patient management. The feedback from the key informants, as well as the literature review, revealed the need to clarify the purpose of this factor. Amending this factor responds to the need for better technology to capture, store and report data for Tribes as this arose as a critical issue during the validation process. It is such an important issue that there exists a National Health Information Technology Modernization project for the IHS which involves several Tribal leaders as well. Robust systems and information generated from sound data capture will also benefit the research and evaluation functions of the Tribes. Some concerns were raised that there are current challenges in this area, so this factor is seen as a critical one to address up front when considering a TSG model. Data sovereignty is also a key factor for data and information management and to enhance Tribal sovereignty.

6.1.2. The CSF Framework: updating the importance and sequence

Apart from improving the descriptions of the individual factors, there were three other key findings from the validation process: my visual representation of the CSF framework was very unclear on the relationships (including dependencies) between each factor; some factors are more important and prevalent than others, so a ranking is likely needed; and while not strictly linear, there is a general sequence to the factors as some should be preceded by other factors to enhance the chances of success.

It was evident that the nine validated factors were interconnected – but I had originally assumed they were of equal importance. The validation exercise clarified that there is a sequencing to the CSFs, and that getting the initial commitment of Tribes; protecting and upholding Tribal identity and culture; and working to generate political will for TSG was essential, and needed to be focused on first. Once those domains were addressed, work to operationalize TSG could occur; before moving to a phase of sustaining TSG through communications and accountability mechanisms. From this I determined that there are three main clusters of the factors:

- **Commit and Initiate Phase**: The critical success factors that get the TSG process going and often they are in play at the same time: drawing on the strength of cultural identity to engage citizens; ensuring Tribal unity and that Tribal leaders are committed and on the same page; and that there is a willing political-legal environment to move ahead. But it must start at home first. Tribal identity and Tribal unity must be achieved before you can move forward – even if there is already a positive political setting (such as ISDEAA) in place.
- **Operationalize Phase**: The critical success factors that resource the Tribe(s) to progress into Tribal Self-Governance, which again can be in play at the same time: financial resources, human resources, data and technology and strong partners.
- **Sustain Phase**: The critical success factors that keep it going once the TSG arrangement is resourced and operational: communications and accountability. It is these factors that will maintain the trust of citizens, leaders, government, funders and partners. To be accountable I believe it starts with effective communication.

Furthermore, while I have clustered the factors into these three phases - it is not as linear as it might appear. It is more of a journey where sometimes participants may need to go back and revisit a particular domain. For instance, if there were significant changes in Tribal leadership (through elections) to those who gained original mandates from their citizens and who were unified

in their commitment, it is possible new appointees may not enjoy the same commitment or vision, and that citizen support can shift. So those involved therefore need to keep returning to re-affirm citizen and leadership support for the continued TSG journey. Changes may also occur on the political front (again through elections) which puts policy and legislative enablers at risk. So those involved might have to go back to advocate for retaining and re-affirming their political support for TSG.

Therefore, I have adapted the visual representation of my CSF framework to that of an open-ended roadmap with fluidity that allows participants to constantly move forward and backward along the journey. See Figure 40 below. The basic sequence remains - from Tribal initiation to operationalization through resourcing and partnering, to sustenance of the TSG pathway with widely shared intelligent information.

Figure 14: Updated Critical Success Factor Framework

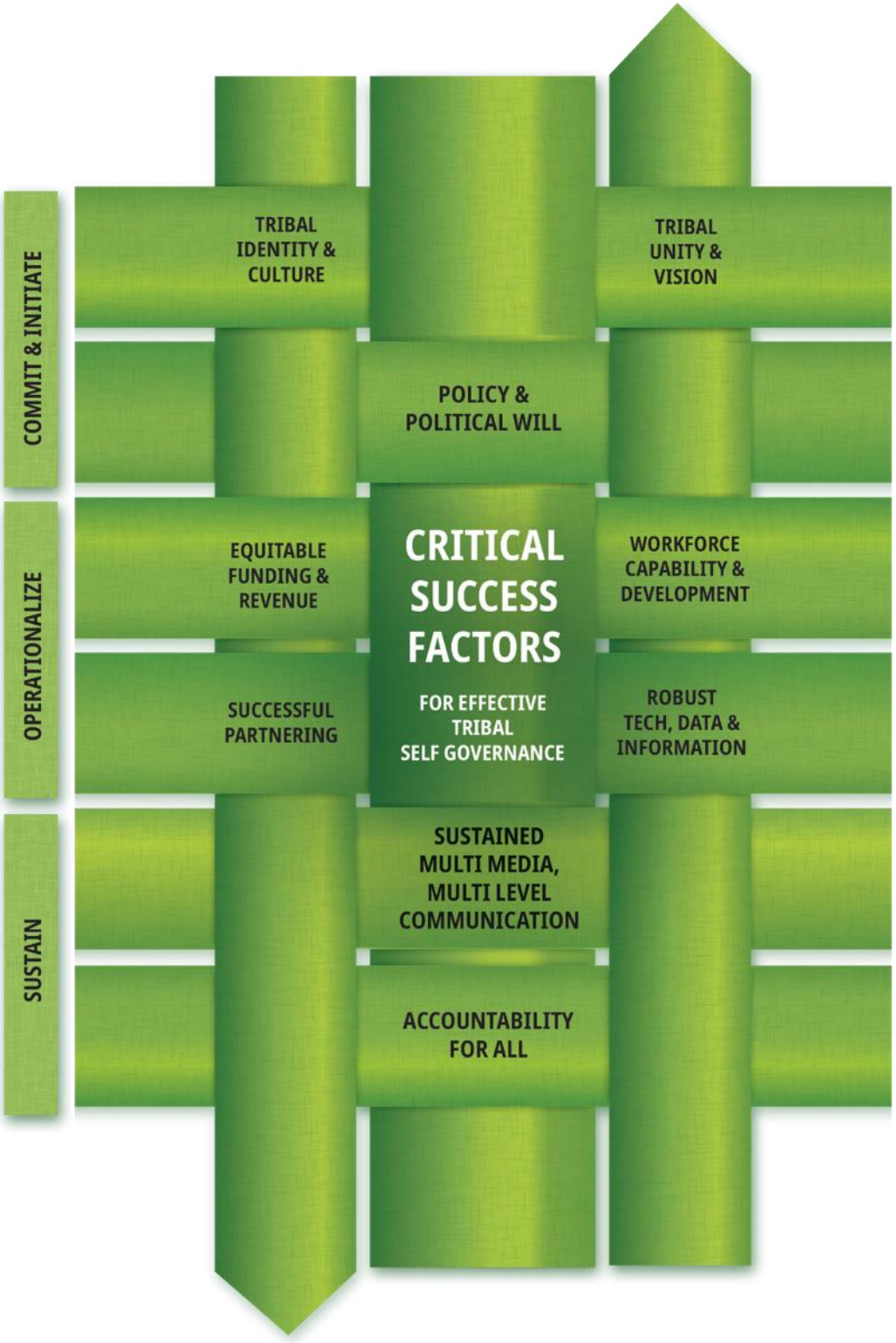


Figure 15: Critical Success Factor Framework with descriptors (new content in purple font)

STAGE 1: COMMIT & INITIATE
Tribal Identity and Culture (previously Infusion of Indigenous Culture)
DEFINING CRITICAL ACTIONS
Tribes need to confirm the Tribal mandate from citizens to opt into TSG agreements, by providing assurance to Tribal citizens that TSG will strengthen and sustain their unique Tribal belief systems, their identity, their native language and customs, their traditional healing and medicines, and their cultural aspirations. This includes embedding cultural thinking into service delivery models. Tribes' unique structures need to be protected in TSG arrangements and acknowledged where they differ from other Tribes (e.g. clan system, village system, chapters). In some cases, Tribes visually display their Tribal identity through physical means – building design, artwork, jewelry, sovereign flags, community icons, carvings, signage, displays and clothing. These displays are both encouraged and celebrated. Similarly, Tribal citizens are often concerned that aligning with other Tribes may impact their own identity and standing. It is important that in TSG arrangements the unique Tribal cultural characteristics are elevated in the process, and even more so when the Tribe partners with other Tribes in regional and national collectives. Culturally-centred dispute resolution mechanisms will help address disagreements. It is essential that such a protocol is agreed early (while things are 'good') so that the protocol can come into effect when there is potential conflict. The risk is that without such a protocol, Tribes may walk away from the table and matters are left unresolved (and worse, the unity is impacted negatively).
DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM
▪ Tuba City Regional Health Care Corporation (part of Navajo Nation) has an Office of Culture and Language as part of its health system to promote use of the language and Navajo customs in health care ▪ Some Tribes maintain native language interpreters on staff (e.g. Navajo, Cherokee) ▪ South-Central Foundation created the NUKA model and aligned their values and operations with this model ▪ Some Tribes have established Sweat Lodges and other traditional healing programs as part of their health care delivery system (e.g. Navajo, South-Central Foundation) ▪ Many Tribes have sovereign flags that are displayed in their communities and at conferences ▪ Health center building designs are very often reflective of the local culture and icons (rivers, mountains) and contain a lot of local artworks (e.g. Gila River Health Corporation; Cherokee Health; Choctaw Health Care ▪ Alaska Native Health Board and Alaska Native Tribal Health Consortium: Dispute Resolution protocol – members agree to Tribal Caucus to discuss issues behind closed doors, and never in front of Government
MEMBER VALIDATION
"If we don't keep our identity in this process, then what's the point? We just become brown people managing a white system". *"It's certainly important to Tribal members to see that their culture is expressed through the [TSG} model".*

"We believe our language restoration project and our drumming, and our dancing are all contributors to our overall health. They are those health indicators…".

"The Choctaw people went back to their traditional governing processes, and they changed their Tribal Constitution to reflect that …"

STAGE 1: COMMIT & INITIATE

Tribal unity and a shared vision (Previously United Tribal Leadership)

DEFINING CRITICAL ACTIONS

Tribes need to unify the commitment to enter into TSG among their own citizens to gain their support for removing Government delivery of programs and replacing it with Tribally-led delivery (at individual Tribal level). Tribes opt into TSG once they have citizen majority support to do so.

Tribes who come together regionally are able to achieve economies of scale for the work they have to do to maintain TSG such as preparing submissions, briefings, workforce development activity and policy making. Larger more wealthy Tribes can support the interests of smaller Tribes with less economic or human capacity. The idea that collective efforts "lifts all boats" not just those with capacity, reigns when working together. Regional entities can gather individual views, synthesize these views and present a position on matters to national entities. Regional entities can appoint representatives to national entities to ensure the linkage to information and accountability.

Tribes need to unify collectively at a Regional and Tribal level in order to influence policy & legislation that supports TSG (see Policy & Political Will above). Without united voice, the Federal Government becomes reluctant to change policy or law due to lack of nationwide support by Tribes. This is especially so to expand TSG opportunities to other Departments where TSG is initially limited to one or two Government Department programs.

Tribes collectively need a shared vision for TSG, so they remain focused on the end-goal. Ideally this is agreed in a Tribal Strategic Plan for Self-Governance and associated communication materials are developed to support continual awareness raising of the key strategic purpose and goals of TSG. Move from Federalization to Tribalization and nation building.

It is important that Tribes are active participants in decision-making regionally and nationally (i.e. Tribes should not belong to regional and national entities but not attend or communicate, while continuing to receive the benefits of the work of others).

Tribes need to remain unified despite their 'place' as either a TSG Tribe, a non-TSG Tribe (where IHS still delivers their services) or an Urban health center serving Indians living off-reservation. It is strategically important that all interests are recognised and wherever possible to speak with one voice, while acknowledging inherent sovereignty of Tribes.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- 370+ Tribes now in TSG arrangements (https://www.tribalselfgov.org/resources/participating-tribes/) out of total 574 Tribes
- New Tribes are opting in each year (e.g. https://www.tribalselfgov.org/slug/5-office-of-self-governance-presentation/)
- Some Tribes have opted out of TSG as their citizens have not supported TSG and wish to retain Indian Health Service program delivery (this is a self-determination decision of self-governing Tribes)

- Self-governing Tribes' creation of the Self-Governance Communication and Education Tribal Consortium (SGCETC) to support TSG Tribes (e.g. organizing communications, resources and conferences) and promoting TSG among Tribes who have not opted in yet
- State and Regional Health collectives (e.g. Alaska Native Tribal Health Consortium (ANTHC); United South and Eastern Tribes (USET) collective of 33 Tribes; Indian Area Health Boards such as Northwest Portland Area Indian Health Board)
- National Council for Urban Indian Health (NCUIH) to represent the interests of urban health delivery entities
- National Indian Health Board (1972) and National Congress of American Indian (1944) enable Tribes to work together on national / federal / Congress issues and to represent Tribal interests with one voice
- National Advisory Groups to BIA and IHS allow Tribes to bring their local and regional voice to national advisory group tables convened with BIA and IHS leadership to influence Departmental policy and activity
- Tribal Strategic Plan for TSG developed with and for Tribes, and frequently updated
- SGCETC responsible for promoting the Strategic Plan and preparing resources for Tribal leaders to promote it (e.g. submissions, statements, media). Key goals outlined:
- Place the Federal Government's Indian programs firmly in the hands of local Indian people being served
- Enhance and empower Tribal government and their governmental institutions (Tribal autonomy)
- Correspondingly reduce Federal bureaucracy and Federal control
- Tribes promoting the benefits of 'nation building' (see Harvard project reports)
- Threats to unity are overcome through collaborations between NCAI. NIHB and NCUIH

MEMBER VALIDATION

"When I think about self-governance … with sovereignty you have to protect or you have to respect people's ability to opt-in or opt-out, because that really is the definition of sovereignty"

"The real principle you're working towards is the greater good of all"

"A unified Tribal system must be there to support everyone. You really have to factor in, how is this going to affect our weakest Tribe or our smallest Tribe?"

"They [Tribes] have worked together to get where we are today – they fought for the original legislation way before President Nixon made his ground-breaking Indian policy"

"How important is Tribal unity? I think it is very, very important… I get back to the importance of Tribal institutions is that you need to have that national body or regional bodies to keep the continuity of your policy together"

"Working together we don't sabotage each other – we are more willing to work together"

STAGE 1: COMMIT & INITIATE

Policy and Political Will

DEFINING CRITICAL ACTIONS

Tribes individually and collectively need to demonstrate strong political will to advocate for changes that empower Tribes to self-govern - while reducing dependence on Federal / Government program delivery in their communities.

Tribes need to work politically and legally with Governments (State and Federal) to create the legislative and policy environment needed for Tribal Self-Governance (TSG). This includes promoting TSG among State representatives who are elected to Congress and influencing policies of the sitting Government (including sitting Presidents / Vice-Presidents) and leaders across both political parties. Aiming for bi-partisan policy helps to ensure continuity.

Tribal leaders (individually and collectively) need to advocate and educate politicians about the benefits of TSG for Tribes and for other citizens. Tribes need to educate officials from other Federal Departments (who have not moved to TSG) about the benefits of them transferring control of Indian programs to Tribes. This helps to expand TSG beyond the initial Departments. Tribes need to find ways to tackle resistance by officials to 'letting go'.

Tribes need mechanisms to maintain a watching brief on emerging policy and law changes to ensure new policies and laws do not undermine or interfere with TSG, but enhance it

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Tribal advocacy and leadership resulting in recognition of Indian rights to self-govern (Nixon, 1970)
- Tribal work with Congress & Senate members that led to passing of TSG legislation (1975) for Bureau of Indian Affairs programs, and expansion to include Indian Health Service programs (1988)
- Expansion of scope of TSG legislation by Patient Protection and Affordable Care Act aka Obamacare (2010) due to advocacy by Tribes with President
- Submissions to Senate Committee on Indian Affairs by National Congress of American Indians (NCAI) and National Indian Health Board (NIHB) by Tribal leaders
- Policy and research technical capacity employed by National Congress of American Indians (NCAI) and National Indian Health Board (NIHB) maintains watching brief on policy and law changes – and informs Tribes (including preparing briefings and submissions)
- Governors, Senate and Congress representatives are continually invited to annual Tribal Self-Governance Conferences and National Indian Health Board conferences to keep them informed

MEMBER VALIDATION

"Really the legislation, the policy work that's done nationally and locally, but you need the political will, not just of Tribal leaders, but to have all these allies on the hill"

"For me Tribal self-determination has become the most successful bi-partisan Indian policy ever enacted by Congress"

"I think that what we're finding is that we're really good throughout Indian country in communicating with Congress"

STAGE 2: OPERATIONALIZE

Equitable funding and revenue (Previously Flexible Funding and Revenue Sources)

DEFINING CRITICAL ACTIONS

Tribes need to advocate for maximum transfer of funds from the Government in the TSG transfer or devolution process (i.e. the Compact Agreement). Whatever the Government is spending at Headquarter, regional and local level – for the Tribe, needs to be transferred to the Tribe. Negotiations and calculations are therefore critical to the process to ensure the Tribe receives maximum and fair funding. The use of the Compact Agreement ensures the Tribe has full flexibility to make its own decisions about the use of the funds once they receive them. Even after transfer of programs and funding, Tribes need to continually advocate for Government to address inequities in funding. Tribes also need to continue to advocate for access all forms of revenue equal to other health operators, over and above what is transferred in the TSG arrangement.

Tribes need to make decisions on whether they will invest their own funds to top-up the Government funding in order to provide additional services or health facilities for their citizens (perhaps in lieu of paying dividends). Tribes who do self-invest would do so while continuing to advocate for Government funding to address inequities.

Tribes need to have a direct role in influencing the Treasury (Office of Budget and Management in US) to influence budgets for health and to make recommendations to the President. Direct influence on Treasury lessens reliance on Government Departments to represent Tribal interests.

Tribes can seek support from Human Rights agencies to reflect on rights of sovereign Tribes and Treaty / UNDRIP misalignment.

Tribes can promote the contribution of health funding to their Tribal economies and employment, social and economic benefits. Equally Tribes can promote the decreasing reliance on Federal Government programs and social benefits, which is often a more positive message to non-native US citizens (thereby creating allyship).

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Tribal advocacy for Government to uphold Federal Trust and Treaty responsibilities (ongoing)
- The National Tribal Budget Formulation Workgroup was established to determine equity gap in funding transferred from IHS to Tribes. Their budget report is regularly updated i.e. For YE2022 the gap was $48bn
- Tribal access to IHS Grants (e.g. workforce, research)
- Access to Medicaid Funding (after passing of Obamacare 2010)
- Access to Contract Support Costs over and above Health Program Delivery costs
- Development of Joint Venture Construction funding to help Tribes build health facilities
- Access to Veterans Affairs funding for patients who are Veterans (over and above IHS funding)
- Direct submissions to Budget Hearings by Tribes
- Report of the US Commission on Civil Rights on “Broken Promises’ relating to under-funding for Native Americans
- Publication of Cherokee Nation contribution to the Oklahoma Tribal economy ($2.4bn) – helps to educate non-native Oklahoma citizens and to win hearts and minds about Tribal success benefitting everyone.

MEMBER VALIDATION

"I think that obviously it is money. I think funding is the greatest challenge…all federal programs are underfunded that serve Indian country"

"We're finding that all of the agencies at the Federal level are less inclined to put funding into self-governance"

"One of the things that's always very discouraging is the fact that Indian health is underfunded, and I see that that's a real barrier to Tribes desiring to participate in self-governance"

"Indian country has two choices … we must push for change or accept a yearly discretionary model process which falls short of meeting our Trust and Treaty obligation fulfilment expectations"

STAGE 2: OPERATIONALIZE

Workforce capability and development (Previously Qualified Workforce)

DEFINING CRITICAL ACTIONS

Tribes need to ensure they educate, inform and enable Tribal leaders to become expert and competent advocates for TSG efforts, and to be strong Tribal leaders individually and collectively. This can include continual briefings by Tribal attorneys on legal matters; providing advice from Tribal policy technicians; providing continual briefings to Tribal leaders from Government, regional and national entities or from internal policy analysts. Tribal leaders should attend formal training opportunities. Similarly, Tribes need to grow and attract competent Health Care Leaders who can quickly gain confidence of Tribal leaders and citizens once Tribes take over from Government program delivery.

Tribes have the option to have Government employees work for the Tribe once the devolution of programs from Government to Tribes comes into effect. This provides some continuity of care as well as immediate capability for the Tribe.

The Government also continues to develop the workforce that operates across the Government-provided service to maintain service delivery to non-TSG Tribes. This is complemented by academic programs offered by universities in medicine and nursing.

Tribes with workforce challenges can develop their own workforce programs and strategies that grow the Indigenous workforce ("Grow your own") to support TSG. This reduces reliance on recruitment of non-Tribal citizens in a tight workforce market.

Tribes with financial resources can attract trained / expert Tribal members to 'come home' to work for the Tribe, through incentives such as Scholarships.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Example: Native Nations Institute at University of Arizona: Indigenous Governance, Law and Policy program
- Attorney briefings to leaders and submissions prepared for Senate Committee on Indian Affairs (e.g. USET statement to Senate Committee 8 March 2023 on Native Communities Priorities - https://www.congress.gov/event/118th-congress/senate-event/333737/text)
- Policy and Research teams at NCAI and NIHB give policy advice to leaders regionally and nationally
- Alaska Native Tribal Health Consortium – Community Health Aide Program; Dental Health Aide and Behavioral Health Aide programs originally developed for Alaska and more recently spread to other parts of the US

- Navajo Nation: Office of Navajo Nation Scholarship and Financial Assistance to 'educate, enable, empower' Navajo citizens by paying for study; paying for transfer back to the Tribe; repaying student debt; providing scholarships.
- Department of Health and Human Services (DHHS): Technology Transfer Centers (TTCs) to provide training and resources for workforces in areas such as Mental Health and Addictions.
- Indian Health Service offers scholarships, workforce training programs, IHS Loan Repayment program, and preferential hiring policies.
- University of North Dakota: Indians in Medicine (INMED) and Recruitment and Retention of American Indians into Nursing (RAIN) programs.

MEMBER VALIDATION

"Workforce is the biggest challenge in Indian health. I think that's the root cause of many of our issues is not being able to find or develop enough qualified individuals..."

"Our biggest challenge at IHS is the workforce. We carry a very high vacancy level and that's been consistent for decades"

"Everyone must know what the Tribal organization is about, what it is aiming for, what is important and what it believes in ... o that as employees they know what they're stepping into"

"The problem is that when you take somebody from the Federal system, they need to understand that working for a Tribe is different. They have to be at least flexible to understand that it's not going to be big bureaucracy"

STAGE 2: OPERATIONALIZE

Robust technology, data and information (Previously Robust Data and Measurement)

DEFINING CRITICAL ACTIONS

At the outset of TSG, Tribes should determine the expected outcomes and indicators for TSG so that achievements, changes, and challenges can be reported to show the benefit of TSG. The Tribe needs to ask itself 'what does the Tribe want to achieve culturally, socially, financially? What health status indicators will demonstrate success?' Data is critical to TSG and to expansion of the TSG program beyond current Departments.

Ideally the Tribes regionally and nationally agree to a set of national health status indicators that they can all commit to. This strengthens the ability to report on positive impacts of TSG on the state of Native American / Alaska Native health since taking over from the Federal Government – and it helps to communicate success to Tribal citizens.

Tribes need to acquire or build Health Information Technology and expertise to support data collection and reporting. They also need to acquire technology for delivery of health care virtually. Tribes need to identify research priorities and draw on partners to support research that supports an evidence-based approach. Tribes need to embed rules and practices for Data Sovereignty and to undertake increased evaluation to assess the effectiveness of their programs once they assume control.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Health Information Technology (HIT) National project in place to re-design HIT across IHS and the Tribes
- Tribal Data Capacity study completed

- Tribal Data Exchange provides a common dataset for TSG Tribes
- Regional Tribal Epidemiology Centers in place across USA to gather data from Tribes for analysis and reporting, and to conduct research
- Baseline Measures Workgroup developed a set of 6 outcome outcomes and 150 indicators in 1994
- Native American Research Centers for Health (NRCH) in place to support Tribally led academic research
- Tele-health technology is in place in a number of TSG communities (e.g. Alaska Federal Health care Access Network)
- University of Arizona Data Sovereignty project

MEMBER VALIDATION

"We really didn't pay attention to data collection and reporting as much as we should have. We just wanted control from the Federal government, we wanted to stop collecting and reporting what we saw as meaningless"

"I would say, make a conscious decision to invest in it from the very beginning. Because you need that to tell your story of how well you're doing and what you're doing"

"We know we need it – but we shouldn't have to do it for the Federal government's purposes as sovereign nations"

"So now we have all these3 different systems across the states – that don't get into anything so we're not advocating it the best way we can because we don't have the data"

STAGE 2: OPERATIONALIZE

Successful partnering

DEFINING CRITICAL ACTIONS

Tribes need to partner with one another locally, regionally and nationally to advance TSG, to learn from one another, and for larger Tribes with greater capacity to protect the interests of smaller Tribes.

Tribes need to partner with State and Federal Governments, local governments, private sector entities and academic institutions to support and accelerate TSG. These partners can offer expertise, resources, knowledge, research and sometimes add capacity to Tribal capability.

Tribes can seek opportunities for investment from partners of resources (human, financial, physical) towards successful win-win outcomes.

Tribes need to partner with Law Firms that understand Indian policy, history and aspirations. They need to understand Constitutional, Fiduciary, Trust and Treaty rights to be effective partners to Tribes. The necessity to protect TSG interests for Tribes is dependent on sound legal advice and representation.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- State and Regional Health collectives (e.g. Alaska Native Tribal Health Consortium (ANTHC); United South and Eastern Tribes (USET) collective of 33 Tribes; Indian Area Health Boards such as Northwest Portland Area Indian Health Board)
- Best Practice conferences to share learnings (e.g. annual Tribal Self-Governance conferences; USET Tribal Best Practices Conference; National Congress of American Indian – exhibitors and presenters on best or latest practices)
- University of North Dakota Medical and Nursing programs for Native Americans; Harvard University on research about economics of TSG

- Partnership of Department of Defence with ANTHC for Alaska telehealth system
- Hobbs, Straus, Dean and Walker LLP and Sonosky, Chambers, Sachse, Endreson & Perry, LLP are frequent sponsors and presenters at TSG conferences and are two high profile law firms among several firms that specialise in Indian policy and legislation

MEMBER VALIDATION

"Partnerships are everything. None of us can do this alone. We need everybody at the helm – Tribes, Federal and State governments, corporate sector, politicians and our national institutions, and our communities"

"We at IHS need the Tribes. We wouldn't want to be doing anything without their support"

"We have to stand together when advocating to government for resources or policy changes in Indian Health"

"I have seen how powerful it can be when our Tribal nation and the State ... maintain a stable and positive partnership"

"One of the most interesting things for me is the amount of successful partnering that happens with other government entities outside of Tribes ... with the State, with the Counties, with local governments. We become very much another government that exists in our regions, and we become a value partner in a way that we weren't valued before"

STAGE 3: SUSTAIN

Sustained multi-level multi-media communication (Previously Sustained Communication and Inclusion)

DEFINING CRITICAL ACTIONS

Tribes need to create communication capability to share TSG information (including achievements, benefits and challenges) with all stakeholders (Government, TSG Tribes, non-TSG Tribes, partners, academic studies). This keeps TSG on the public 'radar' and aims to ensure continuation and growth / expansion of TSG of Government programs, while also winning the hearts and minds of non-Tribal citizens.

Tribes individually, regionally and nationally need to ensure communication occurs in all forms (social media, online, paper, conferences) for all audiences to make it highly accessible.

Individual Tribes need to ensure communications are targeted at their citizens and all the way up to Tribal leaders, State leaders, Federal leaders and Politicians through their regional and national channels.

Tribes need to have a focus on Health (medical) Literacy for their citizens (as those with reduced literacy levels make higher use of services to treat disease and less use of services aimed at preventing disease.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Tribal mail/email lists held by NCAI, NIHB, SGCETC and regional entities to distribute(Adams, 1995) information
- Tribal submissions to Senate Committee on Indian Affairs and Office of Management and Budget
- Appearances at Senate, Congressional and Legislative hearings and placing statements on record in advocating for TSG in health with associated policy, law and funding
- SGCETC maintains a calendar of events for all conferences as well as announcements from agencies
- SGCETC convenes annual TSG Conference

- NCAI convenes two national Congress conferences per year and smaller meetings in between on specific subjects
- NIHB convenes annual Tribal Health Conference and Best Practices forums
- Indian Health Service issues various communications: Dear Tribal Letters; Blogs; Notifications and Alerts and Director convenes Listening Sessions. IHS has a Tribal Consultation Policy for all matters requiring engagement with TSG Tribes
- Government issues Legislative updates ("Washington Report")
- IHS Health Literacy Workgroup (2009)

MEMBER VALIDATION

"You've got to keep communicating constantly…the people have to feel like they can go to the top at any time … your leadership has to be accessible"

"I support the role that SGCETC plays to make sure information gets out to Tribal members but also IHS is disseminating information all the time…"

"So, it really is a multi-faceted effort … SGCETC hub of all the information, to hold the conferences, to hold the meetings, and to do that work too … somebody needs to be the coordinator because Tribal leaders are really busy"

"SGCETC is not a lobbying arm … it's a resource to help Tribes for capacity building, for sharing information, for sharing knowledge"

STAGE 3: SUSTAIN

Accountability for all

DEFINING CRITICAL ACTIONS

Tribal leadership (e.g. Tribal Councils, Tribal Presidents, Tribal Governors) need to ensure accountability / reporting to citizens on progress with TSG and financial management. It needs to be regular, consistent and honest from Tribal leadership. The risk of not doing so may cause citizens to lose support for TSG and/or to retract support for Tribal leadership. If accountability at Tribal level is not strong, a culture of mistrust of leadership by citizens can breed and spread to neighboring Tribes through word of mouth.

Self-governing Tribes need to ensure accountability of national and regional Tribal entities to which they belong, back to Tribes to sustain trust and confidence in regional and national entities. The risk of loss of Tribal members to regional and national entities can undermine their strength and representation and lose the confidence of Government and private partners.

Self-governing Tribes need to maintain accountability to Government for any reporting requirements that they may hold under Agreements / Compacts. Failure to be accountable for expectations under agreements impacts reputation and recognition of Tribes for further TSG opportunities by Government.

Conversely, Tribes must ensure Government accountability to Tribes (Reciprocal Accountability approach) to hold them to account for agreements, commitments, Constitutional and Treaty rights. This may be done informally or legally through Court action.

DEMONSTRATION OF THIS FACTOR IN THE U.S. HEALTH CARE SYSTEM

- Annual State of the Nation addresses (by individual Tribes such as Navajo and by the National Congress of American Indians)
- Tribal communications (websites, social media, annual reports, newspaper media, speaking engagements in communities, conferences)
- Tribal appointment processes to Regional and National entities\, and democratic voting for President(s) of National entities by Tribal leaders.
- Appointment of Tribal Health Care Entity Boards and CEOs / Leaders by Tribal Councils (e.g. Gila River Indian Community selects Board for Gila River Health Care Corporation; Cherokee Nation Tribal Council appointment to Cherokee Health Board) to ensure accountability link between health entity and Tribal Council
- Government Performance and Results Act (GPRA) reporting by Tribes to Government based on agreement Government performance measures
- Reporting by Tribes to Office of Management and Budget (OMB) including submissions to OMB
- Class action by multiple Tribes against Indian Health Service for Contract Support Costs (https://www.dorsey.com/newsresources/publications/client-alerts/2024/6/tribes-win-healthcare-contract-support-costs)

MEMBER VALIDATION

"When a Tribe takes over accountability, if there's a Tribal member that's not satisfied … I know as soon as they get home, they're probably calling the Tribal Chairman. It's inherent in who we are as a culture of our people. Where else in the United States or in the world do, we have that kind of accountability?"

"Federal government reporting is so high level, they're so distant from the ground to the top"

6.2. Quality Assessment

6.2.1. Summary quality assessment

In this qualitative project, I specifically addressed the issue of the interdependence of myself as a researcher, my informants and the framework which has been the main subject of the research. I was very conscious of the appearance that I was evaluating my own work and sought to develop a research approach which showed the trustworthiness of my data and analysis. Following the approach of (Shenton, 2004) and in order to ensure trustworthiness, this research has sought to demonstrate four primary criteria: credibility, transferability, dependability, and confirmability.

Credibility is about the internal validity of the data and can be achieved through techniques such as data, investigator, or theoretical triangulation, participant validation, or rigorous data collection methods. Transferability addresses the applicability of the findings to similar contexts and can be achieved through thick description of the findings from multiple data collection methods. Dependability is similar to reliability in quantitative studies and can be ensured through rigorous data collection techniques, well-documented procedures, and an inquiry audit using an outside reviewer. Confirmability is like objectivity in quantitative studies and can be achieved through techniques such as clear coding schema, audit trail, triangulation, member checking of the data, and conducting a bracketing interview or reflexivity to unpack personal biases. Other strategies for ensuring trustworthiness include familiarizing oneself with the data, maintaining prolonged engagement with the data, using triangulation, persistent observation, negative case analysis, peer debriefing, and maintaining rigorous documentation.

Some common threats to the trustworthiness of qualitative research include reactivity, researcher bias, and respondent bias. Reactivity refers to the potential for the presence of the researcher to influence the behaviour of the participants or the data collected. Researcher bias can occur when the researcher's personal beliefs or perspectives influence the interpretation of the data.

Respondent bias may arise if the participants provide inaccurate or misleading information. Other threats to validity in qualitative research include how observations are explained and interpreted, how the data might be altered to match a particular theory, and how the presence of the researcher may influence the research outcomes. To address these threats, researchers can use strategies such as prolonged engagement with the data, triangulation, persistent observation, negative case analysis, member checks, and peer debriefing. My methods to ensure trustworthiness are described in the table below.

Table 5: Quality Assessment Summary

QUALITY CRITERION	ISSUES	PROVISIONS MADE THROUGH THIS RESEARCH
Credibility	Adoption of appropriate, well recognised research methods	This research used documentary analysis, literature synthesis, interdependent observation and member checking as the four main methods
	Development of early familiarity with culture of participating organizations	Several years of professional participation in Tribal governance and conferences in North America
	Random sampling of individuals serving as informants	Purposive sampling was used to ensure representation from Federal agencies, Tribes (individual/collective) and Partner(s) that could feedback on my hypothesis from different perspectives. These were also persons the researcher had developed relationships with that could be trusted to give an honest view as a result.
	Triangulation via use of different methods, different types of informants and different sites	There was variation in organisation, jurisdiction involving sites and informants
	Tactics to help ensure honesty in informants	These tactics included multiple interviews and discussions to track subtleties and changes in views and perspectives
	Iterative questioning in data collection dialogues	Was adopted as the method of interviewing
	Negative case analysis (one form of negative case analysis may see the researcher refining a hypothesis until it addresses all cases within the data. If the study includes the production of typologies, on completing the initial categories the investigator may revisit the data in order to confirm that these constructs do indeed	The whole research was focused on evaluating and modifying the initial framework

QUALITY CRITERION	ISSUES	PROVISIONS MADE THROUGH THIS RESEARCH
	account for all instances of the phenomenon involved, even if some of the types embrace only one instance)	
	Debriefing sessions between researcher and superiors	Through peer review and supervisory sessions
	Peer scrutiny of project	Through peer review and supervisory sessions
	Use of "reflective commentary" (the section of the commentary dealing with emerging patterns and theories should inform that part of the research report that addresses the project's results, and any discussion in the report of the effectiveness of the study maybe based on the investigator's methods analysis within the reflective commentary)	Reflective commentary was documented by the researcher as various iterations of changes were tested and reviewed
	Description of background, qualifications and experience of the researcher	Statement of positionality
	Member checks of data collected, and interpretations/theories formed	Member checking was a major method and source of data
	Thick description of phenomenon under scrutiny	Provision of policy history for context, plus mix of member views and Tribal leader testimonies and submissions to provide broader Tribal context; literature and documents produced by Tribes – all adds to credibility (using the words of Tribes as the subject matter); in-person observations recorded, reported and repeated
	Examination of previous research to frame findings	Analysis of the literature and other research was undertaken and updated during the research process
Transferability	Provision of background data to establish context of study and detailed description of phenomenon in question to allow comparisons to be made	Considerable background material included
Dependability	Employment of "overlapping methods"	Document analysis, observation, literature, peer review, member checking
	In-depth methodological description to allow study to be repeated	Included in methodology (i.e. prior relationships, observation techniques, review of key documents produced BY the Tribes not just ABOUT the Tribes)
Confirmability	Triangulation to reduce effect of investigator bias	Yes

QUALITY CRITERION	ISSUES	PROVISIONS MADE THROUGH THIS RESEARCH
	Admission of researcher's beliefs and assumptions	Statement of positionality
	Recognition of shortcomings in study's methods and their potential effects	Limitations section
	In-depth methodological description to allow integrity of research results to be scrutinized	Included in methodology
	Use of diagrams to demonstrate "audit trail"	Yes (e.g. Figure 5 and Figure 6 in methodology)

I have also undertaken this research within a specific cultural paradigm which has had the following implications:

- Interdependence and relationality (as opposed to independence and objectivity)
- Holism (as opposed to sectoralism)
- Collectivism (as opposed to individualism)

6.2.2. Validity of Participant Sample

There is always a risk that a sample involved in such a study is not representative of the population of interest and that some sample selection bias may exist which prevents the study from accurately representing the population. All participants for this validation process have long histories of being involved in Self-Governance both on the Tribal side and the Federal Indian Health Service side. It is the reason they were approached for the validation process as their views are more reliable and informed due to their experience. They can each provide strong historical knowledge as well as contemporary knowledge of what is occurring today, and how relevant these factors are today. All participants today are still integrally involved in Indian Health and TSG. Tribal participants were selected from all over the U.S. and not just one State or Tribe. Some work for individual Tribes and some work for or with multiple Tribes such as USET or the ANTHC.

Representation of Tribal participants has come from Alaska to the Northwest, to the south and east of the U.S. as well as from national institutions. In addition to the validation participants, the literature review also included statements and testimony from many other Tribal leaders, which still supported the findings. No one who was approached refused to participate so there is no nonresponse bias.

For the above reasons, I have shown that the findings are valid and accurately represented in the updated CSF framework which emerged after the validation process. More than that – the updated model is stronger in that it now reflects a journey and sequence through use of a roadmap analogy; to reflect the need to respond, revisit and reset should circumstance change.

CHAPTER 7: APPLICABILITY FOR AOTEAROA / NEW ZEALAND

7.1. The Issue of Sovereignty

A sovereign state in international law is a political entity that is represented by one centralized government that has sovereignty over a geographic area. International law defines sovereign states as having a permanent population, defined territory, one government and the capacity to enter into relations with other sovereign states (Shaw, 2003). Article 1 of the Montevideo Convention on Rights and Duties of States (United Nations, 1933) lays down the most widely accepted formulation of the criteria of statehood in international law. It notes that the state as an international person should possess the following qualifications: '(a) a permanent population; (b) a defined territory; (c) government; and (d) capacity to enter into relations with other states.'

One of the underlying tenets of the U.S. TSG model is the status of Tribes as recognized sovereign Nations. Tribes are constantly pursuing the full expression of the government-to-government relationship with Federal and State governments who are also sovereign. The fact that the Self-Governance arrangements through the Indian Health Service (and BIA) are defined as "compact agreements" highlights the status of sovereignty, since a compact is an agreement, treaty, or contract between sovereign States, Nations or countries on matters in which they have a common concern.

Consequently, the first issue to be considered when thinking about self-governing arrangements in Aotearoa, is whether our Tribes are considered sovereign, able to 'self-govern' without interference from other sovereign Nations and to enter into compacts – say with the New Zealand Government to assume control of services delivered to their people. In essence, to do what the U.S. has aimed to through their TSG ISDEAA legislation: to place the Federal government's programs firmly in the hands of the local [Indian] people being served; to enhance and empower

local Tribal governments and their governmental institutions, and to correspondingly reduce the Federal bureaucracy.

The long-held tension over whether Māori leaders ceded their sovereignty when they signed the Treaty of Waitangi with British Crown representatives in 1840, was addressed by New Zealand's Waitangi Tribunal in its report on Stage 1 of the Te Paparahi o Te Raki Inquiry (Waitangi Tribunal, 2018, p.22). The Tribunal concluded that:

> *the Rangatira who signed Te Tiriti o Waitangi in February 1840* ***did not cede sovereignty*** *to the British Crown. [The Tribunal stated] though Britain went into the Treaty negotiation intending to acquire sovereignty, and therefore the power to make and enforce law over both Māori and Pakeha, it did not explain this to the Rangatira. Rather, Britain's representative William Hobson and his agents explained the Treaty as granting Britain the power to control British subjects and thereby to protect Māori . . .. Rangatira would retain their tino rangatiratanga, their independence and full Chiefly authority . . . that is, they did not cede authority to make and enforce law over the people of their territories.*

Furthermore, the Tribunal concluded that:

> *the Rangatira consented to the treaty on the basis and they and the Governor were to be equals.' The Tribunal added 'The Rangatira consented to the treaty on the basis that they and the Governor were to be equals, though they were to have different roles and different spheres of influence. The detail of how this relationship would work in practice, especially where the Māori and European populations intermingled, remained to be negotiated over time on a case-by-case basis.*

The Tribunal said that having considered all of the evidence available to it, the conclusion that Māori did not cede sovereignty in February 1840 was inescapable. The Tribunal said nothing

about how and when the Crown acquired the sovereignty that it exercises today. However, it said, the Crown "did not acquire that sovereignty through an informed cession by the Rangatira who signed te Tiriti at Waitangi, Waimate, and Mangungu."

The Tribunal also concluded (p.38) that He Whakaputanga (Declaration of Independence) (The Sovereign acting by and through the Chief Executive of the Department of Internal Affairs, 2017) was an unambiguous declaration of Māori sovereignty and independence confirming that:

> *the Rangatira who signed it declared that Rangatiratanga, kingitanga, and mana in relation to their territories rested only with them on behalf of their hapu and that no one else but them could make law within their territories, nor exercise any function of government except under their authority. The Rangatira also asked for British protection against threats to their authority.*

The issue of sovereignty is mentioned in an article on Indigenous governance programs in American and New Zealand (Fodder, nd) where it is stated that some of the differences between Indigenous American and New Zealand governance is the 'quasi-sovereign legal status of American Indians under Federal law and the lack of a similar recognition for Māori under the laws of New Zealand'.

7.2. Indigenous Māori first Compact Agreement with the Queen

Dame Claudia Orange in her book 'The Story of a Treaty' (Orange, 1989) reports that in the 1840s after the signing of the Treaty of Waitangi, that a 'sacred compact' had been agreed between the Queen on behalf of Britain colonists, and Māori. However, as the Waitangi Tribunal found in the Ngāpuhi case, Māori leaders weren't aware that their sovereignty was not intact and likely what the true meaning of agreeing to a 'sacred compact' actually meant. Orange writes:

Through the 1840s, officials and missionaries soothed Māori fears by arguing that the Treaty/Te Tiriti was a compact (agreement) between the Queen and the Māori people. During the northern war, Henry Williams printed 400 copies of Te Tiriti (in te reo) and spent many days explaining to Māori groups that, because it was 'a sacred compact', neither the Queen nor the Governor would allow any 'tinihanga' (tricky business). At major meetings, George Grey (arriving as Governor in late 1845) repeated the Treaty promises and said they would be kept. Māori were very uneasy, despite such talk, but still believed they enjoyed a special relationship with Queen Victoria and with her governors.

Although the U.S. introduced the Compact Agreement to their health system (alongside other systems) in the 1990's as a means of recognizing Tribal sovereignty in health care and other programs, one could argue that one of the first Tribal compacts was in fact the Treaty of Waitangi signed in New Zealand in 1840.

7.3. New Zealand's Current Health System Does Not Work for Māori

7.3.1. Waitangi Tribunal: Health Services and Outcomes Inquiry (Wai 2575)

In 2015 the Waitangi Tribunal announced that it would commence a review of contemporary issues affecting Māori known as Kaupapa ((Braun & Clarke, 2021)) inquiries (Ministry of Justice, nd). These inquiries deal with nationally significant issues affecting Māori as a whole and one of these was "Health services and Outcomes." The "Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry" was completed in 2019 (Waitangi Tribunal, 2019).

The Tribunal's task of this review was to focus on the legislative and policy framework of New Zealand's primary health care system and its alleged flaws, when assessed against the principles of the Treaty of Waitangi, focusing on four specific areas: the Treaty-compliance of the Act and framework; funding; accountability; and the nature of Treaty partnership arrangements in

the primary health care sector. In each of these areas, the Tribunal found that the Crown acted inconsistently with the principles of the Treaty. As a result, they upheld the claims filed by several Māori claimants. They noted that (p.15):

> *the legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori. The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing. The prejudice suffered by Māori because of these Crown failures is extensive. The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency on their own. However, we are particularly concerned that the evidence before us indicates that some of the framework's provisions, intended to improve Māori health outcomes and give Māori input into how primary health care is designed and delivered, were not fully implemented or in some cases ceased to operate entirely. This is unacceptable. We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious (Waitangi Tribunal, nd).*

The Waitangi Tribunal also stated that health entities aren't appropriately held to account for achieving equity and that the Crown does not collect sufficient qualitative or quantitative data to truly ensure the primary health care sector is performing for Māori. The lack of this data is identified as a breach of the Treaty principles of active protection and equity.

7.3.2. New Zealand Health and Disability System Review (March 2020)

In 2019-2020 a review of the New Zealand Health and Disability system was undertaken resulting in a final report being published in March 2020 (Ministry of Health, 2020). The Review acknowledged, recognized and reinforced the following (among other findings):

- Te Tiriti o Waitangi obligations of the Crown are not being met.
- Findings of the Wai 2575 review.
- Current inequities are not acceptable.
- The system must understand the needs of individuals, whānau and communities in much more detail and must design and deliver services to address the identified needs.
- The existence of institutional racism and that universal health systems have not improved health outcomes for Māori.
- Existing health services design, purchasing and contracting approaches have increased inequity.
- Embedding of Māori knowledge systems (mātauranga Māori) in the health system is needed.
- Additional investment should be made in kaupapa Māori health services and providers.
- A program to combat institutional racism is delivered.
- Māori health provider development strategies are implemented to ensure there is an appropriate range of services to meet the health and disability needs of Māori whānau and communities.
- Funding is provided for increasing innovation of Māori providers, including supporting the development of more specific population health initiatives for Māori.

- System-level stewardship and leadership must be strengthened with a different governance model.

The review confirmed that improving equity and wellbeing for Māori required immediate improvements in the way the system delivered for Māori. The Review proposed an independent Māori Health Authority (MHA) which reports to the Minister of Health and works alongside the Ministry of Health. The Māori members of the review committee advocated for the MHA to be Māori-led and owned. There was recognition in the review of the need to incorporate Te Tiriti o Waitangi into the system; to update legislation in this regard; to reflect recent interpretations of te Tiriti principles; and to reflect the Māori–Crown partnership.

After the New Zealand Cabinet considered the review, they issued a Cabinet decision in April 2021 (Department of the Prime Minister and Cabinet, 2021) which effectively disagreed that the Māori Health Authority should be independent of the Crown. They did agree to establish the Māori Health Authority, but it would be another Crown entity operating alongside a new Health New Zealand or HNZ (itself a product of merging the former 21 District Health Boards). The Pae Ora (Healthy Futures) Act then came into force on 1 July 2022 to formalise the creation of HNZ and the MHA ("Pae Ora (Healthy Futures) Act," 2022). The opportunity for a Māori-led MHA may have offered opportunities for creative redesign and increase of Māori governance over their health care – therefore paving the way potentially for a self-governing operation. However, as a Crown entity this opportunity was lost.

The Pae Ora Act 2022 does however offer another opportunity where Iwi / Tribal Self-Governance may emerge. The Act offered an opportunity for Iwi and Māori to establish Iwi Māori Partnership Boards (IMPBs) who would partner with the MHA and HNZ to advocate for Hauora Māori interests and to elevate whānau voice in the health system. At the time of concluding this Thesis there were 15 IMPBs recognised in Aotearoa New Zealand ("Pae Ora (Healthy Futures)

Act," 2022)[Schedule 4 Recognition of Iwi Māori Partnership Boards)]. Over time there may be potential for IMPBs to expand their functions and mandate to increase their ability to redesign and govern further aspects of the system.

7.3.3. Repeated System Reviews Show Continued Failures of the System for Māori

Over 30 years ago, the Royal Commission on Social Policy report (The Royal Commission on Social Policy, 1988) highlighted major problems with health policies and practices affecting Māori and the lack of emphasis on Te Tiriti o Waitangi. In 1993, the Durie and Parata Māori Health Review report (Parata & Durie, 1993) also highlighted major gaps in the then Department of Health's approach to Māori Health. Specifically, the Government of the day had a principal objective that "the Crown will seek to improve Māori health status so in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori." One only has to look at the Māori Health Inequities report of 2019 (Health Quality & Safety Commission New Zealand, 2019) to know that across a range of indicators, the health system has continued to fail tangata whenua. One wonders how many more decades must go by before we truly look at a more transformational approach.

Health system reviews since the 1980s, the Wai 2575 claim, and the 2020 Health systems review (among many other reports, studies and reviews), have all demonstrated that the Kāwanatanga health system has not served or acted in the best interests of tangata whenua, and has consistently failed us. Te Tiriti o Waitangi is given limited effect in a privileged illness system currently. Despite the NZ Public Health and Disability Act 2000 Section 4 affirmation that:

> *in order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of, health and disability services.*

Kāwanatanga holds much of the power and resources, and there is limited enforced accountability towards Pae Ora outcomes, effective models of care or positive experiences of care for whānau. Even with the mounting evidence of Māori health inequity and poorer health outcomes, nothing significant has changed within the Kāwanatanga system. In fact, the equity gap in health status has increased. Additionally, the reviews have focused on repairs to an already broken system by adding Māori elements to shore it up. My view is that the system has had well over three decades to do better for Māori – and it just has not. And while this dominant system continues to under-perform for Māori – our people continue to suffer and die at rates much higher than other New Zealanders. The system may work for the dominant population, which is expected since it is designed and delivered by the dominant population.

Overall, it has proven that it does not work for the Rangatira partner, and I believe we need to create an alternative solution for Māori. There are many Māori and Indigenous models already showing success including some mentioned in this Thesis e.g. Te Kōhao Health in Aotearoa and Alaska's Southcentral Foundation's world-renowned successes in primary and secondary care through its Nuka approach (Jones, 2017). These are models led by Indigenous people serving both Indigenous and non-Indigenous communities very successfully. Other features of Indigenous-led health systems such as Tribal Epi Centers (Tribal Epidemiology Centers, nd) which employ Epidemiologists and Researchers to undertake work for the benefit of their Indigenous peoples, could be incorporated. When we are in control of the data to support our own system, we are more than capable of delivering a system that can work better for Māori, and undoubtedly many other non-Māori who also find the westernized system ineffective.

7.4. A Possible Way Forward

Defined by the U.S. Congress ("Tribal Self-Governance Amendments Act of 2000," 2000) the goal of their Self-Governance policy was to permit an orderly transition from Federal

domination of programs and services to provide Indian Tribes with meaningful authority, control, funding, and discretion to plan, conduct, redesign, and administer programs, services, functions, and activities (or portions thereof) that meet the needs of the individual Tribal communities.

Under this Act, Self-Governance has two basic parts:

- the transfer of the responsibility for managing Federal programs (and funds) that serve Indians from existing service providers to the Tribes, and;
- providing Tribes with the broad authority to redesign Federal programs and reallocate Federal resources to more effectively and efficiently meet the needs of Tribal communities.

In my years working among my own people, I have constantly heard the same message – 'give us (Māori) the resources, responsibility and control over our own services and let us redesign services to better meet the needs of our people'. It does not matter whether our people are talking about land, health, child protection, education, waterways, language or housing – the message is the same. So why couldn't we? And what would convince our Government to take the same stance as the U.S. Congress and specifically the Indian Health Service – to be willing to handover control and resources? It could be done without even having to acknowledge sovereignty of tangata whenua (we can leave that debate for another day). However, it could and should be done as one means of fulfilling Tiriti promises though. Even if it is to get past base one by undertaking the initial PSFA assessment and undertaking a demonstration project.

Part of the answer is that we as Māori need to be organized to take it on – and our people must want our leaders to do it. They must want a choice that we think will be better than what they have now. Also, other New Zealanders must believe that a different option, available for them also, will offer better quality and responsiveness than the current system.

The other part is that our Government, and more-so the Ministry, Departmental and Agency executives, need to let go of the reigns. But this is a huge power-shift, and one which I am sure will suffer the same resistance and barriers as the U.S. agency (and Australian) leaders put in place. Furthermore, I have no doubt, and they will offer reasons why it cannot be done as did agency executives in the U.S.

Since it has been determined by the Waitangi Tribunal that Māori Chiefs did not cede sovereignty back in 1840 (even though the Crown is likely to disagree with this), then how could or should Māori exercise this sovereignty and be recognized in the same way that Tribes are recognized in the U.S.? Could the 'sacred compact' be the answer?

Even with all the challenges of implementing the TSG movement in the U.S. – there is widespread legal and moral agreement that Native Americans have sovereignty. Could the same goals of the U.S. Self-Governance arrangements still be pursued and achieved regardless of whether sovereignty is acknowledged by the NZ Government or the British Crown? Could we also:

- reduce government bureaucracy in our lives as Māori?
- place more control in the hands of Māori institutions?
- enhance Māori governance and its institutions?

Could a Māori-led governance entity manage, design and provide a health care system for Māori and other New Zealanders, as a different option to the Kāwanatanga system? We will not know unless we explore this possibility. It moves the focus from constantly "tweaking" the current system every time there is a review or repeated finding of system failure – to an alternative but complementary solution that simply works better for a large section of the population. Maybe it is time we moved beyond the 'one size fits all' system that we have now to truly create a blended system that is more multi-cultural and reflective of the Tiriti partners role in this country as partners.

The answers to these questions could lie in the Matike Mai Report (Aotearoa, 2016) which outlines that Te Tiriti envisaged the continuing exercise of Rangatiratanga while granting a place for Kāwanatanga through defining the different spheres of influence referred to in the Tribunal's Wai1050 report. An approach to defining spheres of influence would require the defining of functions and responsibilities which are clearly the domain of Rangatiratanga; the functions clearly defined as Kāwanatanga (such as those defined as 'inherently Federal functions' in the U.S) and those functions that land in a shared relational sphere where the Tiriti relationship will operate. In the U.S. two primary definitions exist for determining what are 'Inherently Federal Functions':

- Statutory Definition: A function so intimately related to the public interest as to require performance by Federal Government employees.
- Policy Definition: An activity that is so intimately related to the public interest as to mandate performance by government personnel.

The purpose of defining these functions is to clarify what functions can and cannot be contracted or compacted by Federal agencies.

I see no reason why the work needed to define this could not happen. Today there are clearly matters which are the domain of hapū and Iwi alone and often these have been defined by history (such as how we run our Marae) and some have been defined in Treaty settlement agreements (such as the assets, lands and resources now in the hands of hapu and Iwi which are the sole domain of Māori from a decision-making standpoint). Partnerships such as those defined in agreements between District Health Boards or Oranga Tamariki, with Iwi / manawhenua, could be defined as those that sit within the shared relational sphere.

Like the U.S. prior to the introduction of ISDEAA in 1975, Kāwanatanga currently controls the majority of program and service delivery for Māori. It is Kāwanatanga who controls and defines:

- what program and service delivery in all sectors looks like (i.e., in health, education, housing and other social services, conservation, energy, land and water management, fish and game, etc.) from a strategic and operational perspective.
- appropriations to those sectors.
- who gets (or does not get) the resources to manage and deliver the programs and services for the public, and how much of the resource they are provided with to accomplish this.

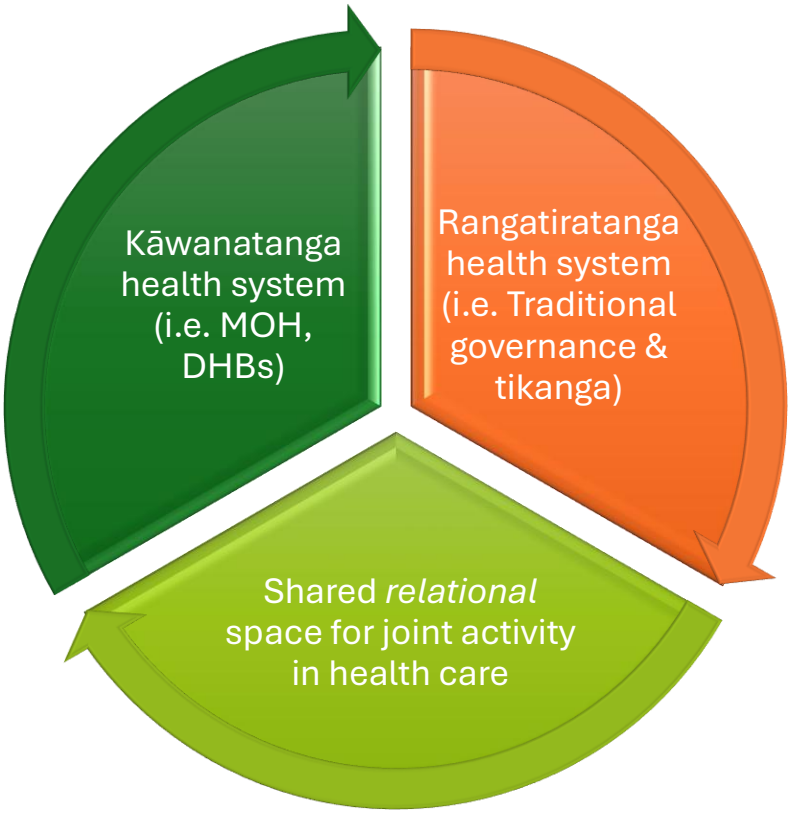
Kāwanatanga may currently consult the Rangatiratanga partner at times when they conduct these functions – and this is often inconsistently done – but still the decision-making rests solely with Kāwanatanga.

It should be possible, as was done in the U.S., to review Programs, Services, Functions and Activities (PSFAs) in each agency to identify what truly ARE inherently Kāwanatanga functions, and what could conceivably be transferred to the Rangatiratanga partner to manage on behalf of Māori. I have not explored the Māori institution(s) that would assume this control, but the point is that the exercise can and should be done to create an opportunity for the Tiriti partners to determine where the spheres of influence could lie. It should also be noted that many self-governing Tribes (and Urban Indian health programs) in the U.S. serve many non-native people. The same could be done in Aotearoa for a Rangatira-governed system. In fact, like any market, if the citizens had the choice of accessing a Kāwanatanga system or a Rangatiratanga system, the 'competition' should ultimately lift the quality of service and increase efficiency and performance. This is something that is missing in Aotearoa right now – Kāwanatanga has no competition so if the standard drops (which it clearly has as evidenced by the persistent inequities facing Māori) there are no other options. As a result, we spent much of our effort trying to fix a fundamentally broken system – rather than overseeing a better performing and more culturally relevant, system.

Whānau Ora Commissioning models take a step toward greater Māori control over Māori resources, but still the dominant system prevails even with the presence of these models.

We could also explore the potential for a similar three-pronged system like the IHS / Tribal / Urban (ITU) model applied to defining Indian Health – ours could be Kāwanatanga / Rangatiratanga / Urban (KRU) or, the urban Māori representation could be included in the Rangatiratanga sphere as suggested by one of the models of spheres of influence in the Matike Mai report. A new model as suggested through the Matike Mai options, could be represented as is the case in Figure 19 below.

Figure 16: An Option for a Tiriti-based Model of Health Governance



Undertaking a detailed analysis of the PSFAs of agencies is a great deal of work – but it is a good start to begin looking at what PSFAs are actually better delivered by Māori and what should remain with Kāwanatanga as 'inherently Kāwanatanga functions.' This would need to be a joint

exercise of Kāwanatanga and Rangatiratanga partners – it cannot be done by Kāwanatanga alone as the bias would be significant.

In fact, given the lessons we can draw upon from the U.S. and the Indian Health Service TSG implementation, conducting this work in Aotearoa's health system would make for a useful demonstration project that could be evaluated, in the same manner as the U.S. initiated their TSG journey with its' 10 demonstration projects of TSG in the Indian Health system.

7.4.1. We will Need Tribal Unity Working to a Shared Vision

One of the strengths of the national Tribal institutions in the U.S. is that they are very clearly embedded in the fabric of AI/AN Tribal organizational system, but they also provide a very clear avenue for national advocacy and being the keeper of Tribal knowledge, concerns, research and inter-governmental activity. Our Tribes in Aotearoa do not have a national 'NCAI equivalent' which is equipped with a team of legal-political analysts who can perform the similar functions of the NCAI and the NIHB to represent the interests of Tribes; to provide technical support for Tribes; to maintain communication and information flow with Tribes; and to help hold the government to account. Like the NCAI and NIHB, such an entity would be bipartisan and solely focused on facilitating the voice of tangata whenua in the country's affairs.

Additionally, we have yet to create a unifying and single mission mandated by Iwi leaders, that everyone can pursue. We need a unified vision for health, we need Iwi mandated health priorities which are regularly reviewed. We need our own data repositories such as Tribal Epi-centers.

7.4.2. We Need to Place a monetary value on the Equity Gap

We also need to undertake the same exercise as the National Tribal Budget Workgroup to quantify the funding gap to address Māori inequities. It is not enough to say we need to address inequities – we need to quantify what it will take to address those inequities and to have that

appropriation set aside for the Rangatiratanga system to tackle this long-standing issue. The Rangatiratanga system needs to be part of the budget appropriation process with Kāwanatanga to achieve this. Detailed analysis needs to occur for the Vote: Health budget and how much of this is being prioritized to address Māori health inequities.

The total current Vote Health for 2024/25 is $29,637 million (approximately $29.6 billion) (Minister of Finance, 2024).

Breakdown of Māori Health Services Spending 2024/25:

- Hauora Māori services: $749 million (3% of the Vote) is allocated to enable Health New Zealand | Te Whatu Ora to deliver hauora Māori services;
- Kaupapa Māori mental health and addiction services: In 2022/23, $235.4 million was spent on Kaupapa Māori mental health and addiction services. This represented 10.3% of the total mental health and addiction expenditure;
- Integrated Primary Mental Health and Addiction (IPMHA) services: While not exclusively for Māori, 20.1% of people using these services in 2022/23 were Māori;
- Access and choice services: 74.3% of new people seen in Kaupapa Māori access and choice services were Māori;
- Te Aka Whai Ora (Māori Health Authority): The disestablishment of Te Aka Whai Ora is set to save the government $35.5 million. However, frontline services previously delivered by Te Aka Whai Ora will now be delivered through increased funding for Health New Zealand, Te Whatu Ora.

Although a crude calculation, in its simplest terms, a minimum of $3.34 billion should be spent annually on health care for Māori based on its population share, and more should be spent to address the inequities evident within the system. Currently there is no easy way of determining whether Māori are in fact accessing or receiving $3.34 billion worth of care through hospitals,

clinics, pharmaceuticals, community health and disability services. While challenging, we should push to determine where the Māori share of Vote: Health is going. We should bring our best heads together (much like the U.S. Tribal Budget Workgroup) to figure out a methodology and determine where our share of Vote: Health is currently going; what our 'fair share' should be; and what the equity gap is. It took the U.S. workgroup three years to develop their first iteration of this figure, but it provided them with a platform for ongoing updating of the equity gap that continues today. We should then plan on the basis that funds follow patients – if non-Māori people for instance choose to access the Rangatiratanga system, the funding should move with them from the Kāwanatanga system.

7.4.3. Opportunities for applying the CSF Framework in Aotearoa

The table below aims to recommend actions we could take in Aotearoa to move the TSG agenda along here. It is possible we could also suggest a set of demonstration pilots such as those used to kick off the TSG movement in the U.S. These suggestions below refer specifically to a Māori health system:

Table 6: Potential methods for adapting the TSG agenda in Aotearoa

Critical Success Factor	Essential inclusions
Tribal (Hapu, Iwi, Māori) Identity & Culture	• Draw on our traditional governance model of hapu (He Whakaputanga and Te Tiriti o Waitangi) to support our local and national governance models – inclusive of our processes for reaching consensus. • Bring our hapu, Iwi and Māori leaders and workforce together to share our Māori models of care, quality improvement & best practice activities that blend traditional medicines and healing with western practices. Actively design & promote our Indigenous models of care and service delivery across Aotearoa and internationally. • Include our Kuia and Koroua in authentic roles within our Indigenous health organizations. • Continue to include, promote and invest in Te Reo Māori Promote throughout our own health system

Critical Success Factor	Essential inclusions
Tribal Unity and a Shared Vision	• Recommendations discussed above. • Kāwanatanga investment to enhance Rangatiratanga capacity to partner (invest in national legal-policy analytical capacity and data sovereignty)
Policy & Political Will (Kāwanatanga and Rangatiratanga)	• Continually advocate for upholding of Treaty and fiduciary rights and the Tiriti relationship • Co-create legislation and policy (applicable to all Kāwanatanga agencies) to conduct PSFA and budgetary analysis as baseline for partnership negotiations on 'spheres of influence' and defining inherently Kāwanatanga functions. • Continue to strengthen close relationships between Kāwanatanga and Rangatiratanga leaders so each understands one another's aspirations and capabilities. • Kāwanatanga to ensure inclusion of Rangatiratanga leadership in new legislation and policy proposals that will impact on social determinants of health for Māori
Workforce Capability and Development	• Create opportunities for Kawanatanga and Rangatiratanga leaders to jointly undertake learning sessions with their peers in the U.S. to draw in lessons from their 30 to 40-year experience. Invite subject matter experts to support legal-political analysis of the Aotearoa environment and potential opportunities. • Develop workforce plan for growth, recruitment and retention of the Māori health workforce for all levels (leadership, health administration and service delivery). • Invest more in scholarships, loan repayment plans and recruitment / transfer incentives to advance Māori representation in the sector. • Establish a preferential hiring policy for the Indigenous workforce. • Ensure benefits and coverage for Kāwanatanga employees in health and transferrable and applicable for Rangatiratanga employees. • Identify, invest in and actively grow new and young Māori leaders in health care. • Strengthen partnerships with academic institutions to train more Māori in all levels of health care (leadership, administration and delivery).
Equitable Funding & Revenue	• See recommendations discussed in detail above

Critical Success Factor	Essential inclusions
Successful Partnering	• Continue to facilitate more regional partnerships between Tribes and Tribal organizations for advocacy, collaboration, sharing expertise and resources, coordinating efforts, procurement and other beneficial outcomes • Continue to support partnerships at local authority level and with private sector that support health technology advancement; environmental protection; impacts on social determinants of health for Māori
Robust Technology, Data and Information	• Continue to update Māori health baseline indicators and establish "starting point" to create before & after status for any new arrangements agreed between Kāwanatanga and Rangatiratanga • Establish common dataset for all Iwi (regardless of technology used to capture) to monitor population health for agreed indicators. • Develop and implement strategy for Health Technology including EHRs/PHRs & telehealth across all Iwi • Iwi to establish research priorities and have the capacity to undertake desired research. • Fully resource Iwi Epi center(s) to support Iwi to engage with members, partners and government and to provide evidence for resources. • Establish Data Sovereignty and Data Sharing protocols between Tribes and with Government to access Government-held data on Tribal members
Sustained multi-media multi-level Communications	• Ensure national mechanisms for holding & disseminating information among Rangatiratanga health institutions. • Create multiple communication methods for political and agency engagement and use all forms of media to disseminate information including conferences, web-based applications, social media. • Create marketing and promotional avenues and resources for Rangatiratanga progress
Accountability for All	• Ensure mechanisms in place for accounting to the public (Māori and non-Māori), leadership, politicians and government committees and leaders. • Create transparent reporting tools (for both Kāwanatanga and Rangatiratanga systems) • Hold each system accountable: report out to Political committees & forums of each partner.

Critical Success Factor	Essential inclusions
	• Create mechanisms for Kāwanatanga and Rangatiratanga leaders to come together regularly

In summary, I think it is important to try something different and transformational. We can do no worse than the current system which has proven to fail us as Māori, time and time again. Albert Einstein is widely credited with saying "the definition of insanity is doing the same thing over and over again but expecting different results." Well . . . at what point do we say, "let's try something else?" The least we can do for the benefit of our people and their health and wellbeing, is to explore something that has been tested by our Indigenous whānau in the U.S. and who have kindly offered to share with us their trials and tribulations, and their successes and achievements. We as Māori, and our Government, have the chance to learn from that journey and be a part of history in Aotearoa.

CHAPTER 8: CONCLUSIONS

8.1. Nine Critical Success Factors for Tribal Self-Governance in Health Care

This thesis set out to test a research question I developed in 2018 – whether nine Critical Success Factors (CSFs) capture what is essential to support an effective model of Tribal Self-Governance (TSG) in health care in the United States. I defined these nine factors through evidence gathered in the period 1999-2017 and observations, as a result of my interaction with the Tribes in Self-Governance during that same period. Having attended a total of 12 TSG conferences and completed several site visits with Indian Health Service and self-governed Tribal health institutions at a local, regional / State and national level (over 60 site visits in total), I had amassed a lot of documentation about TSG, and learned a lot from TSG stakeholders – both Tribal and Federal. From this I developed nine common themes which I found were a constant subject of discussion; or a high priority for Tribes or they were mechanisms used by Tribes to support their TSG activity, and these themes formed my CSF framework. I summarized key findings from my documents and my key observations over the years from my personal interactions. The resulting framework incorporates this mix of behavioral and systemic factors:

Behavioural

(1) Policy & Political Will

(2) Unified Tribal leadership

(3) Successful Partnering

(4) Infusion of Indigenous culture

Systemic

(5) Qualified Workforce

(6) Flexible Funding & Revenue sources

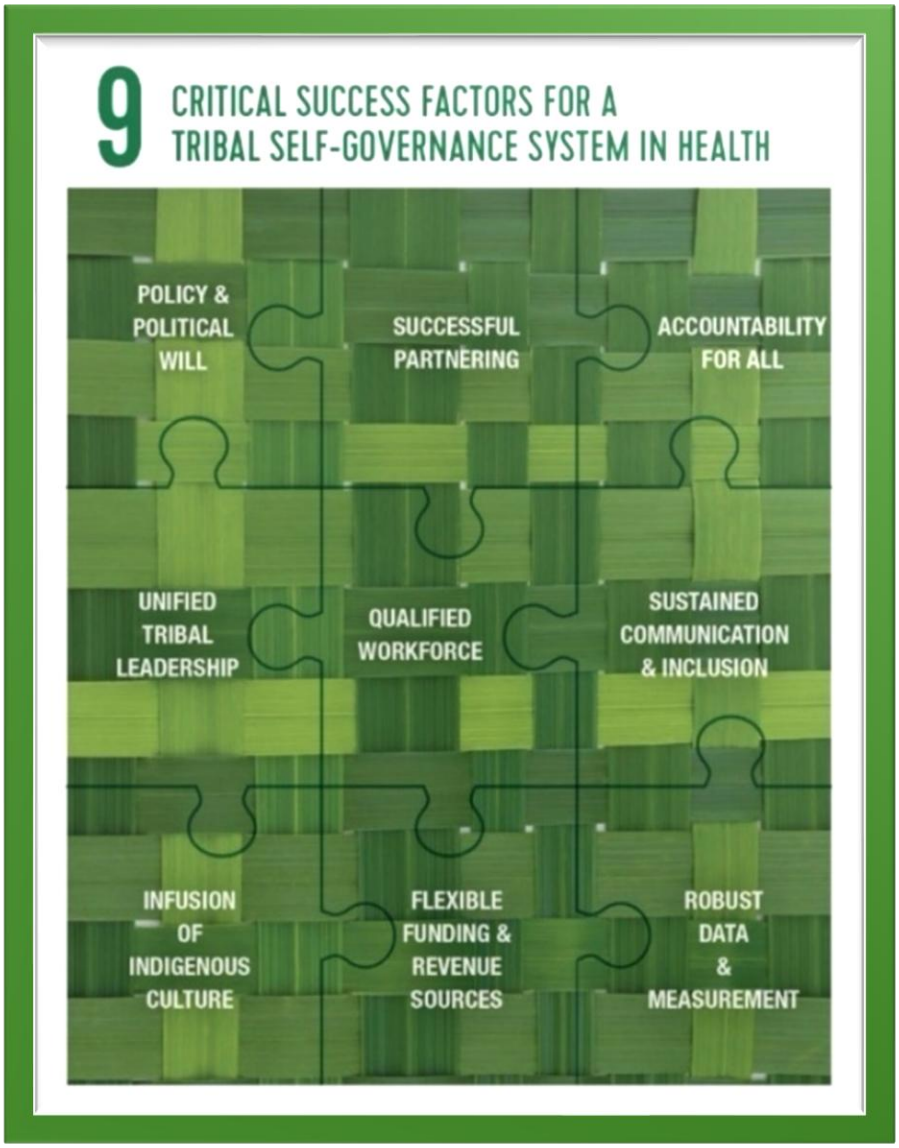
(7) Robust Data and Measurement

(8) Sustained Communication and Inclusion

(9) Accountability.

Figure 17: Original 9 Critical Success Factors for a Tribal Self-Governance System in Health

Note. Photo credit: Mara Andrews



My theory was that all nine factors must be in force at the same time and that when addressed together, the 'whole' provides greater assurance for the success and effectiveness of TSG of health care. I presented the framework in the form of a puzzle weaving diagram to demonstrate

the interconnectedness of the factors along with an appended summary of key characteristics of each factor.

8.2. Testing the Validity of the Framework

To test the validity of my framework, I used two methods: review of any further literature related specifically to these factors that had emerged in the 2018-2023 period, along with an expert interview and member validation process. The member validation involved me interviewing Tribal and Federal leaders who have operated within the TSG system for many years. I asked them first what they thought were critical factors for TSG and then asked them to review and comment on my CSF framework. I found that the validation process affirmed the nine critical success factors and that nothing was identified as missing or redundant. In fact, the validation process served to enhance the factors by adding a level of specificity and clarity that did not exist in my original theory (for instance amending 'unified Tribal leadership' to 'Tribal Unity and a shared vision'). Member feedback provided that level of clarity – and for all factors, feedback from all interviewees, whether Tribal or Federal, was consistent.

The main benefit of the validation process was the contributions made by the interviewees in clarifying the relative importance of each factor and this differed for the participants. However, the feedback also indicated that factors escalate in importance at different times based on external environmental and political forces or other events of the time. Moreover, the validation process highlighted the fact that this needs to be a flexible journey and one that might need to be repeated as leaders change both on the Tribal and Government side.

At the time of writing, for the Federal leadership operating the Indian Health Service, the severe shortages in workforce and significant vacancy rate, is their greatest challenge as it is significantly impacting their ability to deliver services to direct service Tribes. For the Tribal leadership, things like Tribal unity, successful partnering, cultural inclusion and communication –

are not high priorities as these necessities have long been attended to and embedded within their TSG system many decades ago.

While workforce gaps are also a challenge for Tribes (and still regarded as a critical factor), the greatest challenge facing the Tribal leadership is the severe underfunding of Indian health, in all areas (capital and operating). There is very strong Tribal unity on this issue and evidence of this as recently as 2018, 2019, and 2020 with the release of significant reports on the funding issue by the U.S. Commission on Civil Rights, Senate Hearings and the Tribal Budget Formulation Workgroup update of April 2020 which signaled a total $48 billion gap in the system. It is the lack of political will on the Congressional side that continues to impede resolution of this longstanding issue.

The 20 years from 1995 to 2015 however, one of the most significant issues for self-governing Tribes was the non-payment by the Federal government of Contract Support Costs – the overhead cost of managing transferred programs. It was during the Obama Administration, a very pro-Indigenous President, that many outstanding issues were resolved, and following a Supreme Court decision, the issue of CSC was settled, and many Tribes awarded and paid significant outstanding settlements.

The validation process helped to rank the importance of the factors and the relative sequencing of the factors. To understand the sequencing, it was necessary to reflect on the U.S. history of Self-Governance, the policies that were in place, the Tribal institutions that were created, and the work that Tribes have done since the landmark 1975 legislation was first enacted. It is that history that has clarified ‘what needs to come first’ – but also, what should have been earlier (such as embedding a stronger data indicator framework and health technology platform nationally among the Tribes). Some of the issues being worked on in more recent years are certainly, in hindsight, things that would have been more beneficial to Tribes today if they had been resolved much earlier in the TSG journey. It is these lessons that offer the benefits of hindsight.

8.3. Adapted / Final CSF Framework

8.3.1. Enhancing the individual critical success factors

As mentioned previously, the advice from the validation process added greater specificity to each of the factors, mostly to reflect the advances in technology (such as health technology and the internet) since TSG began over 30 years ago, but also to stress important characteristics of each factor. For instance, ensuring Tribes are not just working together, but are working towards a shared vision, or stressing 'equitable' funding rather than flexible funding. The factors were updated as follows:

Table 7: Original Critical Success Factors & Changes Made Following Validation Process

ORIGINAL CRITICAL SUCCESS FACTOR	CHANGES MADE (IF ANY) FOLLOWING VALIDATION PROCESS
Unified Tribal leadership	Amended to 'Tribal Unity and a shared vision'
Infusion of Indigenous culture	Amended to 'Tribal Identity and culture'
Policy & Political Will	Retained
Qualified Workforce	Amended to 'Workforce capability and development'
Flexible Funding & Revenue sources	Amended to 'Equitable Funding and Revenue'
Successful Partnering	Retained
Robust Data and Measurement	Amended to 'Robust technology, data and information'
Sustained Communication and Inclusion	Amended to 'Sustained multi-media, multi-level communications'
Accountability for all	Retained.

Along with tightening up these descriptors, I also condensed the descriptors for each of the factors to include other information either found in the literature or provided by the interviewees.

8.3.2. Ranking and Sequencing the Factors

It was clear from the validation process what the most important factors were which held the entire TSG system together. From my analysis I determined that *the* most important factors are TRIBAL UNITY AND A SHARED VISION and TRIBAL IDENTITY AND CULTURE since without these, the Tribal journey toward TSG cannot even get off the ground. Tribal leaders affirmed this in their discussions:

- TRIBAL UNITY AND A SHARED VISION: The need for leaders to work together to cement a commitment to the TSG journey is critical. If the group is not solid from the start, then I believe it will fail as participants will not hold strong in the face of adversity along the way.

- TRIBAL IDENTITY AND CULTURE: Exemplified by the statement "If we don't keep our identity in this process, then what's the point? We just become brown people still managing a white system!"

The remaining factors follow a generally logical sequence:

- POLICY AND POLITICAL WILL: Without a favorable legal and policy framework in place to offer the TSG opportunities – it is almost impossible to wrestle resources and control of government resources away from agencies to transfer to Tribes to govern in their own way. Again, Tribes need to use their political, cultural and collective strength tied to their vision of self-determination, to create, lobby for and establish these favorable settings.

Once the unity, vision and favorable conditions are in place, then operationalizing the TSG environment requires resources – financial resources, data and technology, people resources and allies / partners:

- EQUITABLE FUNDING & REVENUE: To support the sustainability of TSG. We know from the U.S. experience that they currently do *not* attract equitable funding from the IHS, but they have been able to increase revenues since the enactment of Obamacare. There is no doubt though that many Tribes are also subsidizing health care through their own revenues. Consequently, while this is still a critical success factor, it has not stopped TSG in the U.S. – it remains one of the unresolved issues for Tribes that they are actively advocating for.

- ROBUST HEALTH TECHNOLOGY, DATA AND INFORMATION: To measure and monitor progress, achievements and health indicators / outcomes, robust health technology is needed; clear outcome goals and strong data collection. Tribal Epi-Centers are a classic example of assuring this.
- WORKFORCE CAPABILITY AND DEVELOPMENT: Workforce within the TSG environment is critical – from informed, educated, passionate leadership, to highly capable health administrators, to suitably qualified health practitioners, both traditional and western. Again, the TSG system still functions when all of these ideals are not in place (viz: the significant workforce shortages), but it is an area requiring early strategizing, planning and investment.

- SUCCESSFUL PARTNERSHIP: Partners will be necessary for many Tribes to augment their current capacity and resources. They will take the form of academic institutions, government partners, private entities and philanthropic entities.

Having operationalized the arrangement – the next phase is sustaining it. This will require the parties to keep the faith with their citizens as losing their support for their Tribal leaders would be catastrophic. Citizens will call for the return of resources, program and service control back to government if they do not believe Tribal leadership is being effective. They have the power to

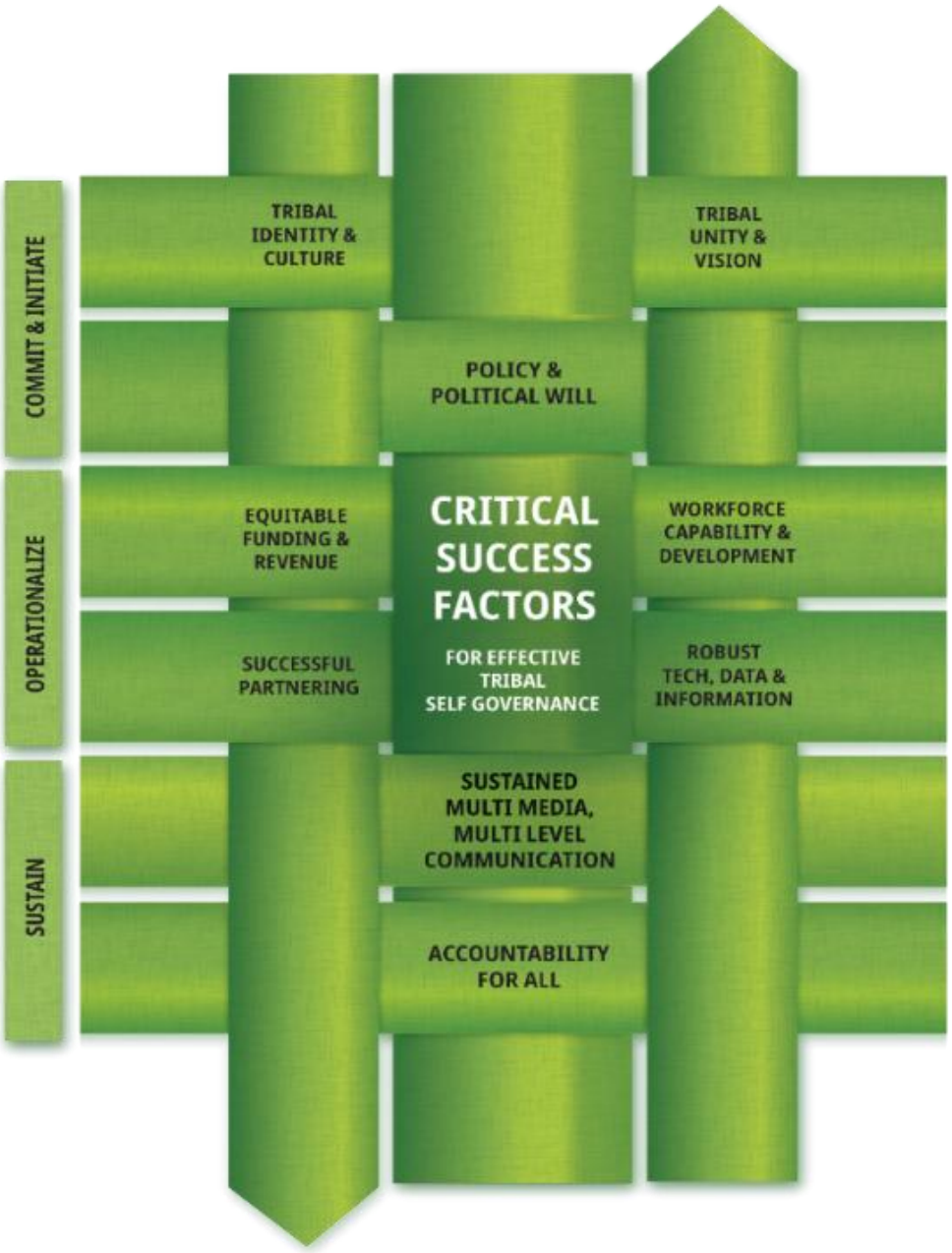
remove Tribal and Government leaders through elections if they are dissatisfied. Citizens need to be informed; they need to receive excellent care in a way they have never received before; and they need to be reported to (among other stakeholders). Hence the final two factors are clustered toward the latter part of the TSG journey:

- ACCOUNTABILITY FOR ALL: maintaining accountability and reporting to citizens and to Government funders; IHS accountability for its direct service provision to the Government Accountability Office.
- SUSTAINED MULTI-MEDIA MULTI-LEVEL COMMUNICATIONS: continuing to communicate with citizens, Tribes, politicians, academic institutions and other stakeholders to keep people engaged in TSG.

8.3.3. Connecting the factors in the Framework

There was some feedback during the interviews that signaled some confusion with my original visual of the framework which aimed to show the connectedness of the nine factors. The 'puzzle' analogy was not clear as some puzzle pieces do not 'touch' other pieces, so it was unclear what their connection was. Also, each 'puzzle piece' was the same size so did not indicate relative importance or sequence. The visual also did not signify this was a journey, one that might need to be repeated if circumstances change and one that is not linear. As a result, I created a roadmap theme when re-presenting the CSFs in a new format – see Figure 21 below:

Figure 18: Updated CSF Framework for effective Tribal Self-Governance



The vertical strands intentionally move forward and backward because sometimes participating Tribes need to go back to review or repeat key steps such as re-affirming the TSG commitment with citizens after Tribal elections, or reviewing Government policies as new laws are

introduced that potentially impact on TSG legislation. Ultimately it a constantly shifting landscape because of political changes in Tribal leadership and in U.S. leadership.

8.4. Key Learnings

The CSF framework reveals several key learnings – especially for others considering the design of a Self-Governance policy and pathway. The following includes as brief description of the most essential recommendations required for each factor of a Self-Governance policy and implementation plan:

(1) *Tribal identity and culture:* That Tribes assess and confirm their traditional governance models, philosophies, cultural practices and protocols, traditional healing practices, language and customs so that their Tribal aspirations for self-governing, are grounded in their authentic and unique identity. Tribes must be clear who they are, where they have come from, how their ancestors traditionally led the Tribe, what they believe in and where they want to go – to come to the table with a sense of purpose and clarity

(2) *Tribal Unity and a shared vision:* That Tribes recognize they are stronger working together at local, regional and national levels and should establish appropriate institutions to facilitate unity around a common vision for the processes and outcomes of Self-Governance.

(3) *Policy & Political Will:* That Tribes must have the support of their citizens to embark on a model where the Tribe assumes control of services and programs – from a model where government has historically performed this role. That such a policy be applicable across government, with Tribes able to choose where they wish to start in terms of negotiating Self-Governance arrangements (i.e. some may choose health, or some may choose education or housing or justice programs). That even if legislation and supportive policy is in place to support a self-governing model, it does not mean that

implementation of those same laws and policies will occur seamlessly. It requires considerable pressure by Tribes to ensure the policy is implemented as planned – coupled with comprehensive support from Government at all levels (including agency leaders) that they will be accountable for full implementation of the law and policy. Agency executives must be precluded (and even penalized) from putting up barriers, rules or regulations that circumvent the intent of the policy

(4) *Equitable Funding & Revenue*: That an appropriate funding formula for a transition to Self-Governance is calculated and assessed from the outset, to provide the foundations for negotiations equitable funding for self-governing Tribes. That allowances for inflation be integrated along with surety that Tribes are entitled to their equitable share of any new appropriations (without competitive grant or proposal-driven processes). This funding formula must include the costs of governing and managing, and not just delivering, health care. Tribes should have access to government procurements arrangements.

(5) *Workforce Capability & development*: A Tribal workforce strategy is developed at the outset which assesses the baseline workforce and identified gaps and needs for all levels of health governance, administration and delivery. Those resources are attached to implementation of the strategy. That academic institutions (preference Tribal academic institutions) partner with Tribes to develop appropriate curricula and qualifications for Tribal positions. That a Tribal hiring preference policy is implemented, along with assignment of all current government employee benefits (in the government health system) to Tribal employees.

(6) *Successful Partnering:* That as well as strong Tribal and academic relationships, Tribes actively seek out other partnerships with the private sector, technology suppliers,

educational institutions among others, to maximize opportunities, efficiencies and outcomes

(7) *Robust Technology, Data and Information:* That a set of baseline measures is agreed at the outset between Tribes and a strategy for collection, storage and reporting of that data (including accessing government datasets and including health technology infrastructure), and that a Public Health surveillance function (such as the Tribal Epicenters) is established up front to perform and coordinate this activity

(8) *Sustained Multi-Media Multi Level Communication:* That there is a robust mechanism and defined responsibility for who will be responsible for ensuring two-way information flow, and robust Tribal Consultation by agencies from the outset

(9) *Accountability for All:* That an accountability framework is established which defines accountabilities of Tribes to their citizens / service users; Tribes and Government (at all levels) to each other; and Tribes and Government to the wider public in relation to any public funds.

The above is a brief overview of the key elements of a robust Self-Governance framework to increase its chance of success, and to avoid the array of challenges and barriers that U.S. Tribes have faced (and still face) after 30 years of implementing their Self-Governance policy.

If there is a major learning for me from the U.S. experience, it is that when these core elements are not addressed at the outset with appropriate strategy and resources, Tribes and government experience considerable angst, frustration and at times, confrontation, over the years. This absorbs considerable time and resources for everyone involved, that would be better spent on facilitating positive health outcomes for the population. When one or more of these elements are missing, under-resourced or undermined – as has happened in the U.S. - the result is that the

stakeholders are distracted trying to resolve these gaps and barriers, instead of being focused solely on delivering innovation and results. In other words, it does nothing but take leadership's eye off the ultimate vision of improving the health and wellbeing of the people.

8.5. Opportunities for Aotearoa / New Zealand

In considering the implications for Aotearoa / New Zealand, I felt that the results of this work, now that it has been validated and updated, can provide significant new opportunities for health care governance in Aotearoa.

An important issue is the matter of Tribal sovereignty. This is so fundamental to the Tribal Self-Governance model in the U.S. along with Treaties, the Federal Trust and fiduciary responsibility and the government-to-government relationship of Tribes, States and the Federal government. In Aotearoa, the issue of sovereignty of Māori has been addressed by the Waitangi Tribunal, but with their powers reduced to making recommendations only and not having legislative authority, the issue of formal acknowledgment of tangata whenua sovereignty remains unresolved.

However, work has been done by the Independent Monitoring Mechanism (IMM) on behalf of the National Iwi Chairs Forum, to explore how constitutional transformation could accommodate recognition of the sovereignty of Kāwanatanga and Rangatiratanga as expected in Te Tiriti o Waitangi. In fact, the IMM offers potential models of relationship between the Tiriti partners based on defining each other's independent spheres of influence as well as a relational sphere of joint influence. To me this opens the door for consideration of a different model in Aotearoa's health care system through conducting the work to define these spheres in the health system.

What is evident from the Wai2575 Tribunal findings in the Hauora report (2019), as well as the New Zealand Health and Disability System Review (2020a) is that both point to persistent failure of the current system for Māori. Despite several reviews of the health system since the 1980s, reconfigurations of the system, prioritizing of Māori health and repeated Māori health

‘planning’ for change, inequities continue to persist. This all points to a system not able to serve Māori in a manner that Māori as tangata whenua rightly deserve, and a system not able to adapt itself to meet Māori need. It is this exact same frustration about the persistent failures of Government, which led U.S. Tribal leaders to advocate for Tribal Self-Governance. They have proven they can utilize resources much more efficiently; they can tailor solutions for their local communities, and that they can be held more accountable through being much closer to the citizens they serve.

For me, the persistent failure in Aotearoa cannot be tolerated anymore and we need to stop ‘tweaking’ the system and look at a complete transformation. Drawing on the U.S. methodology, to initiate this work I have recommended some key steps:

(1) Identify the NZ health system as a demonstration project for Kāwanatanga and Rangatiratanga to jointly conduct a detailed analysis of the Programmes, Services, Functions and Activities (PSFAs) overseen by Kāwanatanga currently. The U.S. has set a precedent for how this can be done.

(2) Conduct a detailed analysis of the budget of the health system and specify the equity gap in funding used to address Māori health need (especially since Māori providers receive less than 2% of the entire $20 billion budget) despite being 16.5% of the population and a Tiriti partner to the Crown.

(3) Jointly identify from the PSFAs, what PSFAs could be classified as ‘inherently Kāwanatanga functions’ rightly *only* able to be governed by the Crown; what PSFAs could conceivably be governed by either Kāwanatanga or Rangatiratanga; and what PSFAs could be jointly managed within a relational sphere of influence.

(4) Jointly develop options for Rangatiratanga to assume control of agreed PSFAs (governance and attached budget) as an evaluated demonstration project, which could offer lessons for expansion of the project within the health system and to other systems currently solely governed by Kāwanatanga. The NZ Health System review has already signaled a Māori Health Authority (MHA) is on the table however the proposed MHA functionality is minimal (and even marginalized), and the MHA is expected to report to the Crown's Minister of Health. In a true Tiriti model, the MHA if it were the manifestation of the Rangatiratanga partner, would report to tangata whenua – not to the Crown.

(5) Kāwanatanga invest in building the capability and capacity of Rangatiratanga by resourcing adequate legal-policy analysis capability (this could be a Secretariat of the National Iwi Chairs Forum for instance) to enable the Rangatiratanga partner to have the sustained capacity to partner effectively with Kāwanatanga in the relational sphere.

8.6. Areas for Further Research

I have highlighted above areas that I believe could and should be researched further to provide the foundations needed to consider a complete transformation of the NZ health system. This has far-reaching implications. If successful – there is no doubt that tangata whenua will push for similar transformation of other systems currently governed by the Crown.

In terms of the foundational work for the Critical Success Factor framework, the work would always benefit from broader member validation beyond those that were involved in this study. Engaging more Tribes to consider the framework and to add their perspective will only strengthen it and I would welcome further research being done in that way. Additionally, it would be useful to seek the perspectives of Tribes who have actively self-determined NOT to enter Self-Governance arrangements. While I do think the reasons for their decisions have emerged within this

study from the study participants, to hear it directly from non-self-governing Tribes would paint a more complete picture.

8.7. My Personal Reflection

I thoroughly enjoyed completing this study even though at times it was incredibly daunting to imagine how one is expected to generate an 80,000+ word thesis that will be useful to Aotearoa. However, the sense of satisfaction is not so much in completing this thesis. The real joy and inspiration for me has come from having the opportunity to walk alongside the Indigenous people of the U.S. on their TSG journey over the past 24 years and to have had the privilege of being a 'sponge' for the knowledge and experiences that they have so gratefully shared.

I like to think of this past 24 years as a train journey. I was like an extra passenger on their train welcomed to come aboard for the ride. I got to watch and learn from the itinerary planners, the train-drivers, the conductors, the maintenance people, the people keeping the tracks safe, the people providing sustenance to the passengers, the cheerleaders on the sides of the track, and the supporters at each station signaling another milestone in the journey. Despite people switching the tracks at times, changing or removing some of the stations, not providing enough wood for the steam engine, and putting huge mountains in front of that train – the train kept going. Despite some of the train staff changing from time to time, and the cheerleaders on the side also changing – the train has kept going.

This thesis is really the story of that train journey, and I am so grateful to have been on the train. I made amazing friends, I learned a huge amount of political and technical knowledge, I read such intelligent analysis, and I felt such immense passion and belief amongst the leaders and passengers on this journey.

I hope to be on the next train for the next 20 years – this time on a railway track in Aotearoa! I invite our friends from the U.S. to come join our train journey so that we can repay you for your generosity.

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CHAPTER 9: APPENDICES

9.1. APPENDIX A: Information on major Indian Health Policies

Additional information to support timeline diagram in Introduction section:

YEAR	MILESTONE	IMPACT
1789	**United States Constitution: July 4th 1789**	The United States Constitution mentions 'Indians' and 'Tribes' three times: • Article I, Section 2, Clause 3 states that "*Representatives and direct Taxes shall be apportioned among the several States . . . excluding Indians not taxed*."[1] • Article I, Section 8 states that "*Congress shall have the power to regulate Commerce with foreign nations and among the several states, and with the Indian Tribes*",[2] determining that Indian Tribes were separate from the Federal government, the states, and foreign nations,[3] and; • The Fourteenth Amendment, Section 2 amends the apportionment of representatives in Article I, Section 2 above.[4]
1800s		
1823 - 1832	**Chief Justice Marshall's Indian Law Trilogy** **(*3 key Supreme Court decisions*)**	The Marshall Trilogy is a set of three Supreme Court decisions affirming the legal and political standing of Indian Nations. • *Johnson v. M'Intosh* (1823), holding that private citizens could not purchase lands from Native Americans. • *Cherokee Nation v. Georgia* (1831), holding the Cherokee nation dependent, with a relationship to the United States like that of a "ward to its guardian." • *Worcester v. Georgia* (1832), laid out the relationship between Tribes and the state and Federal governments, stating that the Federal government was the sole authority to deal with Indian nations. The key to understanding Marshall's opinions is that they managed to preserve important Tribal rights, including Tribes' limited sovereignty and right to Self-Governance, while legitimizing what had already taken place—the expropriation of Indian lands.
1830	**Indian Removal Act 1830** ***(Removal and relocation of***	Indian removal occurred generally in the period 1830 – 1850 Removal was to be voluntary (per the official policy enunciated in the Northwest Ordinance), but Jackson made clear that Tribes refusing to relocate would lose Federal protection and be subject to state laws and jurisdiction. In the end, those who did not move 'voluntarily' (generally through fraud or coercion) were removed forcibly.

YEAR	MILESTONE	IMPACT
	Indians from their lands 1830 – 1850)	The Cherokee Trail of Tears is the most infamous of the forced marches to the new Indian Territory in Oklahoma; many other Tribes suffered similar displacements, with consequent loss of life and cultural upheaval. By the end of the Removal Era, around 1850, most Tribes had been removed from the East, although factions had escaped removal and eventually gained Federal recognition and protection.
1871	**Indian Appropriations Act 1871**	The Indian Appropriations Act of 1871 had two significant sections. First, the Act ended United States recognition of additional Native American Tribes or independent nations and prohibited additional treaties. Thus, it required the Federal government no longer interact with the various Tribes through treaties, but rather through statutes: That hereafter no Indian nation or Tribe within the territory of the United States shall be acknowledged or recognized as an independent nation, Tribe, or power with whom the United States may contract by treaty: Provided, further, that nothing herein contained shall be construed to invalidate or impair the obligation of any treaty heretofore lawfully made and ratified with any such Indian nation or Tribe. — Indian Appropriations Act of 1871[10][11] Before 1871, the United States had recognized the Indian Tribes as semi-independent. The 1871 Act also made it a Federal crime to commit murder, manslaughter, rape, assault with intent to kill, arson, burglary, and larceny within any Territory of the United States.
1886	**U.S. Supreme Court Decision (U.S. v Kagama) – defined plenary power of Federal Government**	The 1871 Act was affirmed in 1886 by the U.S. Supreme Court, in United States v. Kagama, which affirmed that the Congress has plenary power over all Native American Tribes within its borders by rationalization that "The power of the general government over these remnants of a race once powerful . . . is necessary to their protection as well as to the safety of those among whom they dwell."[12] The Supreme Court affirmed that the U.S. Government "has the right and authority, instead of controlling them by treaties, to govern them by acts of Congress, they being within the geographical limit of the United States. . . . The Indians owe no allegiance to a State within which their reservation may be established, and the State gives them no protection."[13]
1887	**General Allotment Act (Dawes Act) 1887**	Named for Senator Henry L. Dawes of Massachusetts, Chairman of the Senate's Indian Affairs Committee – It came as another crucial step in attacking the Tribal aspect of the Indians of the time. In essence, the act broke up the land of most all Tribes into modest parcels to be distributed to Indian families, and those remaining were auctioned off to white purchasers. Indians who accepted the farmland and became "civilized" were made American citizens. But the Act itself proved disastrous for Indians, as much Tribal land was lost, and cultural traditions destroyed. Whites benefited the most; for example, when the government made 2 million acres

YEAR	MILESTONE	IMPACT
		(8,100 km2) of Indian lands available in Oklahoma, 50,000 white settlers poured in almost instantly to claim it all (in a period of one day, April 22, 1889). – Congress instituted a program of forced land allotment (Dawes Act 1887). The Dawes Act provided for the breakup of Tribally owned reservation lands by allotting them to individual Indian owners. Individual ownership, it was argued, would speed the "civilization" of Indians by breaking up the old communal life and making them individualistic farmers. The Indian land base dwindled from 138 million acres in 1887 to 48 million acres by 1934. Although the policy of allotment was later repudiated, its legacy can still be seen in the high parcelization, varying and multiple ownership, and jurisdictional "checkerboard" of many reservations.
1900s		
1921	**Snyder Act 1921** November 2, 1921 (Public Law 67-85)	The **Snyder Act** directed that the Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes: ▪ General support and civilization, including education. ▪ For relief of distress and conservation of **health**. ▪ For industrial assistance and advancement and general administration of Indian property. ▪ For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of **water supplies**. ▪ For the enlargement, extension, improvements, and repair of the buildings and grounds of existing plants and projects. ▪ For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, **physicians**, Indian police, Indian judges, and other employees. ▪ For the suppression of traffic in intoxicating **liquor and deleterious drugs**. ▪ For the purchase of horse-drawn and motor-propelled passenger-carrying vehicles for official use. ▪ And for the general and incidental expenses in connection with the administration of Indian affairs.
1924	**Indian Citizenship Act** June 2, 1924 (Public Law 68-175)	On June 2, 1924, Congress enacted the Indian Citizenship Act, which **granted citizenship to all Native Americans born in the U.S**. The right to vote, however, was governed by state law; until 1957, some states barred Native Americans from voting.

YEAR	MILESTONE	IMPACT
1934	**Indian Reorganization Act 1934** June 18, 1934 (Public Law 109-221)	Indian Reorganization Act, also called Wheeler–Howard Act, (June 18, 1934) aimed at **decreasing Federal control** of American Indian affairs and **increasing Indian self-government and responsibility**. In gratitude for the Indians' services to the country in World War I, Congress in 1924 authorized the Meriam Survey of the state of life on the reservations. The shocking conditions spurred demands for reform. The act curtailed the future allotment of Tribal communal lands to (white) individuals and provided for the return of surplus lands to the Tribes rather than to homesteaders. It also encouraged written constitutions and charters giving Indians the power to manage their internal affairs. Finally, funds were authorized for the establishment of a revolving credit program for Tribal land purchases, for educational assistance, and for aiding Tribal organization. The Reorganization Act remains the basis of Federal legislation concerning Indian affairs. The act's basic aims were reinforced in the 1960s and '70s by the further transfer of administrative responsibility for reservation services to the Indians themselves, who continued to depend on the Federal government to finance those services.
1945 - 1961	**Termination Act(s)**	Series of laws passed across the U.S. to terminate Tribes and their Federal-Tribal relationships. 109 Tribes 'terminated'
1959	**Transfer Act** Title 42—the public health and welfare (2002)	Authorized the transfer of maintenance and operation of hospital and health facilities for Indians to the Public Health Service. This Transfer Act also encompassed all services related to the delivery of health care to Indian people. This was the beginning of specific directives on how such health care services were to be provided. i.e., through the construction of facilities.
1959	**Indian Health Facilities Act** **Indian Sanitation Facilities Act** July 31, 1959 (Public Law 86-121).	Authorized funding for the construction of Indian health facilities to be used to assist in the construction of non-Federal community hospitals which service Indian and non-Indian patients. Such funding required the consent of the Tribe. This Act expanded both the Snyder Act and the Transfer Act to include, as part of the health care services to be provided to Indians, the provision of sanitation facilities and services. The Act includes authority to construct facilities and acquire land for sanitation purposes.
1968	**Indian Civil Rights Act 1968** April 11, 1968 (Public Law 90-264).	The Indian Civil Rights Act of 1968, provided many, but not all, of the guarantees of the Bill of Rights applicable within the Tribes. The legislation was passed by the 90th U.S. Congressional session and endorsed by the 36th President of the United States Lyndon Johnson on April 11, 1968. It arose in the 1960s after Congress held a series of hearings about the authority of Tribal governments. These hearings talked about the abuses that many Tribal members had endured from the

YEAR	MILESTONE	IMPACT
		"sometimes corrupt, incompetent, or tyrannical Tribal officials." In response, the Indian Civil Rights Act was enacted.
1970	**President Nixon: Recognition of Tribal Self-Determination**	In 1970, President Nixon, in a "Special Message to Congress on Indian Affairs," laid the foundation of a new Federal policy to promote Tribal self-determination (Nixon, 1970). Since that time, the policy of the Federal government has been to promote Tribal self-determination. In his statement he said: *It is long past time that the Indian policies of the Federal government began to recognize and build upon the capacities and insights of the Indian people. . .. The time has come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indian acts and Indian decisions. Federal termination errs in one direction, Federal paternalism errs in the other. Only by clearly rejecting both extremes can we achieve a policy which truly serves the best interests of the Indian people. Self-determination among the Indian people can and must be encouraged without the threat of eventual termination. In my view, in fact, that is the only way that self-determination can effectively be fostered . . .*
1975	**Indian Self-Determination and Education Assistance (ISDEAA) Act 1975**	Congress recognized the importance of Tribal decision-making in Tribal affairs and the primacy of the nation-to-nation relationship between the United States and Tribes through the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Public Law 93-638 Contracting and Compacting) in 1975. Subsequent amendments to the ISDEAA strengthened the Federal policies supporting Tribal self-determination and Self-Governance.
1976	**Indian Health Care Improvement Act (IHCIA) 1976** The Indian Health Care Improvement Act of 1976 (25 U.S.C 1601, et seq.) www.ihs.gov	The Indian Health Care Improvement Act (IHCIA), the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, was made permanent when President Obama signed the bill on March 23, as part of the Patient Protection and Affordable Care Act. The authorization of appropriations for the IHCIA had expired in 2000, and while various versions of the bill were considered by Congress since then, the act now has no expiration date. The Indian Health Care Improvement Act of 1976 (25 U.S.C 1601, et seq.) and the Snyder Act of 1921 (25 U.S.C 13) comprise the basic legislative authority for the Indian Health Service. Listed below are these Acts along with several other Acts which give Congress appropriations for the Indian Health Service.
1988	**ISDEAA amendments** **(Title III added)**	In 1988, Congress amended the Indian Self-Determination and Education Assistance Act (the Act) by adding Title III, which authorized the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) to enter into Self-Governance compacts for the first time under a demonstration project.

YEAR	MILESTONE	IMPACT
1994	**ISDEAA amendments** **(Title IV added)**	In 1992, Congress amended the ISDEAA to authorize a Tribal Self-Governance Demonstration Project within the IHS, giving federally-recognized Tribes the option of entering Self-Governance compacts to gain more autonomy in the management and delivery of their health care programs.
2000s		
2000	**ISDEAA amendments** **(Title V added)**	Congress **permanently** authorized the IHS Tribal Self-Governance Program by creating Title V of the ISDEAA through Public Law 106-260. [President Obama Administration]
2000	**Alaska Native and American Indian Direct Reimbursement Act, Public Law 106-417**	This Act amended the IHCIA to make permanent the demonstration program that allows for direct billing of Medicare, Medicaid, and other third-party payers, and to expand the eligibility under such program to other Tribes and Tribal organizations.
2010	**Indian Health Care Improvement Act - Public Law 94-437**	The act implements the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs. This Act expanded the Snyder Act authority. The Act became known as the "437" Act. The Indian Health Care Improvement Act (IHCIA) has been identified as the **cornerstone legal authority** for the provision of health care to American Indians and Alaska Natives, was **made permanent** when President Obama signed the bill on March 23, 2010, as part of the Patient Protection and Affordable Care Act. <u>In the legislation Congress found the following [Clause 1601]:</u> (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people. (2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States. (3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services. (4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

YEAR	MILESTONE	IMPACT
		(5) Despite such services, the unmet health needs of the American Indian people are severe, and the health status of the Indians is far below that of the general population of the United States. [Clause 1602] Congress declared that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians— (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy; (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; (3) to ensure maximum Indian participation in the direction of health care services to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities; (4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population; (5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian Tribes and Tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination; (6) to ensure that the United States and Indian Tribes work in a government-to-government relationship to ensure quality health care for all Tribal members; and (7) to provide funding for programs and facilities operated by Indian Tribes and Tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

9.2. APPENDIX B: Ethics Approval

Date: 04 December 2019

Dear Mara Andrews

Re: Ethics Notification - **4000022021** - **Doctoral Study: "Testing the relevance and appropriateness of nine Critical Success Factors for an effective 'Tribal Self-Governance in Health Care' system in the United States"**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Human Ethics Low Risk notification

Professor Craig Johnson
Chair. Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

9.3. APPENDIX C: Information Sheet to Key Informants and Consent Form

Key Informant: Interview Consent Form

INFORMATION SHEET – INTRODUCTION TO THE RESEARCH

1) The researcher Mara Andrews is a PHD student enrolled with the Research Center for Maori Health Development at Massey University, New Zealand
2) The topic of research is entitled: "*Critical Success Factors for an effective Tribal Self-Governance in Health Care system in the United States*"
3) The researcher has developed a draft Critical Success Factor framework ('the draft CSF framework') for Tribal Self-Governance of Health in the USA from her experience and exposure to Tribal Self-Governance in the period 1998 – 2018, and now wishes to test the validity of this framework with key stakeholders involved in Tribal Self-Governance in the USA. Key informants from Tribal, State / Regional and National level including Tribal Leaders and Self-Governance personnel from the Indian Health Services have been identified as key informants
4) The framework has been developed based on a number of activities / initiatives / legislative / policy and other factors that the researcher believes contribute to, and provide evidence for, each Critical Success Factor
5) Interviews will explore your thoughts and perspectives on:
    a. Critical Success Factors for Tribal Self-Governance
    b. The CSFs proposed by the student
    c. Any CSFs you believe are important but are excluded from the current framework
6) Your interview may be recorded to ensure accuracy and if so a copy of the transcript will be sent to you for validation to ensure statements captured are accurate
7) You do not have to answer every question and can stop the interview at any time

Key Informant Consent Form

Research project title: "Critical Success Factors for an effective Tribal Self-Governance in Health Care system in the United States"

Research investigator: Mara Andrews, Massey University Student ID [redacted]

Research Participants name: _____

Title / Role: _____

Thank you for agreeing to be interviewed as part of the above research project. The interview will take approximately 1 hour. We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time. Ethical procedures for academic research undertaken from New Zealand post-secondary institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read this information sheet and consent form and then sign this form to certify that you approve the following:

- that the interview may be recorded and a transcript will be produced and that you will be sent the transcript and given the opportunity to correct any factual errors
- the transcript of the interview will be analysed by Mara Andrews as research investigator
- access to the interview notes / transcript will be limited to Mara Andrews and academic colleagues and supervisors reviewing her research process
- any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
- the actual recording will be destroyed 6 months post-graduation
- any variation of the conditions above will only occur with your further explicit approval

Quotation Agreement

I understand that my words may be quoted directly. With regards to being quoted, please initial next to any of the statements that you agree with: I wish to review the notes, transcripts, or other data collected during the research pertaining to my participation.
I agree to be quoted directly
I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used
I agree that the researchers may publish documents that contain quotations by me

All or part of the content of your interview may be used;

- In academic papers, policy papers or news articles
- Any media that we may produce such as spoken presentations

- On other feedback events

By signing this form I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described above;
3. I have read the Information sheet;
4. I don't expect to receive any benefit or payment for my participation;
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

_____

Printed Name

_____ _____

Participants Signature Date

_____ _____

Researchers Signature Date

Contact Information

This research has been reviewed and approved by Massey University Ethics Committee. If you have any further questions or concerns about this study, please contact:

Name of researcher Mara Andrews
Full address [redacted]
Tel: [redacted]
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What if I have concerns about this research?

If you are worried about this research, or if you are concerned about how it is being conducted, you can contact the Chair of the Massey University Ethics Committee

INTERVIEW QUESTIONS

Introduction: I have been following Tribal Self-Governance in Health in the US since 1998 and from to time have attended annual conferences. I have also visited a number of Tribes, regional and national agencies across the US including NCAI, NIHB, IHS, USET, NWPAIHB, ANTHC, Gila River Health Corporation, Seattle Indian Health Board, Seminole Nation, and Phoenix Indian Medical Centre among others. I have gathered and read a lot of information over this period and completed a literature review. From this I developed a Critical Success Factor Framework comprising 9 CSFs that I believe are essential to create and sustain an effective Tribal Self Governance (TSG) in health system. So as not to bias your responses to questions I am not sharing the CSF framework up front, but instead seeking your views on what you think the CSFs are for TSG in health and then checking for alignment with my draft framework. I am happy to share the framework at the end of the interview. Are you comfortable to proceed or do you have any questions before we begin?

1) What does TSG mean to you and why is it important?
2) What do you think TSG means to the Federal Government?
3) Thinking about a situation where you are asked by New Zealand Tribes whether they should embark on a process of implementing TSG in health care – what advice would you give them?
4) If you were asked the same question by the NZ Government what advice would you give them?
5) What do you think has been critical to sustaining TSG in the health care system in the US?
6) How important is Tribal unity in the realm of TSG in health? Would TSG work if Tribes worked alone?
7) Thinking about how information is shared from Tribes to Government and vice versa - and from Tribes to other Tribes – what mechanisms do you think have been successful?
8) What have been your greatest challenges or barriers to TSG in health?
9) *Finally: Discussion on the students CSF framework*

9.4. APPENDIX D: Observation Report and Key Learnings

STATE / PROVINCE	PLACE	INSTITUTION	KEY LEARNINGS
Alaska	Anchorage	South Central Foundation (SCF): Nuka System	Values-based recruitment; family-centred care (customer-owner), Nuka model
Alaska	Kenai	Kenaitze Tribal Health and Social Services, Denaina	Effective health, justice & social service integration [adapted Nuka model]
Alaska	Anchorage	National Tribal Public Health Summit (conference 2017)	Shared commitment to indigenous approaches to Public Health. Enablers and disenablers of indigenous health and wellbeing
Alaska	Anchorage	Alaska Native Tribal Health Consortium (ANTHC)	Tele-health to address remote needs; State-wide oversight models. Vision: Alaska Natives are the healthiest people in the world
Arizona	Phoenix	Phoenix Indian Medical Center (PIMC)	Largest Federally operated Indian Hospital. Relationship-Based Care model. Effective hospital monitoring systems (dashboard reporting)
Arizona	Phoenix	Desert Vision Youth Residential Treatment Center	Indigenous spiritual models of residential addiction treatment (Federal facility)
Arizona	Window Rock	Navajo Nation (Headquarters)	Tribal Government, lawmaking, investment & economic development. Exercising Sovereign Immunity
Arizona	Gallup	Gallup Indian Medical Center (IHS)	Federal Facility. Balancing walk-in client needs with scheduled care in a high need population
Arizona	Chinle	Chinle Comprehensive Care Center (IHS)	Applying the indigenous "Tapestry of Wellness" model of care
Arizona	Tuba City	Tuba City Regional Health Care Corporation	Tribally-governed; inclusion of Navajo native speaking navigators. Started own Cancer Centre
Arizona	Pinon	Pinon Health Care Center	Integration of sweat lodge with typical primary care services
Arizona	Hopi	Hopi Health Care Center	Remote health centers serving dispersed populations
Arizona	Phoenix	Gila River Health Corporation (GRHC) - Tribal	Influence of tribal leadership approach to hospital management. Ability to re-prioritise resources (e.g. tobacco taxes for health promotion)
BC Canada	Victoria	Ministry of Health, British Columbia	Resolving Federal/Provincial Health policy jurisdictions with First Nations indigenous needs
BC Canada	Surrey	Fraser Regional Health Authority	Integration of tribal leadership & culture (Blanket Ceremony of CEO to symbolize CEO commitment) with a Provincial Health Authority
BC Canada	Vancouver	St Paul's Hospital (Providence Health)	Trying to embrace cultural intelligence. Integrating faith-based hospital care models with First Nations models of care
BC Canada	Vancouver	First Nations Health Authority (FNHA)	First Nations governance of a Province-Wide First Nations health system
Florida	Orlando	National Tribal Self-Governance Conference (2016)	Tribal leaders informed and knowledgeable on legislative and policy aspects of health. Highly organised collective - use this to influence policy
Florida	Saint Lucie	Seminole Tribes of Florida	Wealth can create similar problems to poverty (e.g. access to drugs). Concierge health system doesn't protect you from risks
Hawaii	Honolulu	Papa Ola Lokahi, Hawai'i	Coordinating State-wide efforts in Native Hawaiian health. Huge potential
Hawaii	Manoa	University of Hawaii at Manoa	Workforce development: Growing the Native Hawaiian medical workforce. Joint He Huliau Conference
Hawaii	Honolulu	Queens Health System	Ali'i Trust hospital system challenged to include indigenous voice in a US-governed State
Hawaii	Maui	Hui No Ke Ola Pono (Native Hawaiian Health)	A Native Hawaiian model of care integrating medical and traditional healing
Hawaii	Kapolei	Blue Zone Project	Multi-agency community-specific approaches to wellbeing (food supply & choices)
Hawaii	Maui	Haleakalaa (Volcano)	Meaningfulness of significant sacred sites to indigenous wellness
Hawaii	Kaunakakai	Na Pu'uwai (Molokai)	Indigenous-managed Kupuna day care programme example
Hawaii	Honolulu	He Huilau Indigenous Health (conference 2016)	Evidence of indigenous approaches to health care gains that work!
Maryland	Washington DC	National Congress of American Indian (Embassy)	560 tribal national governance body: generating a collective voice on national issues / influencing policy. Very skilled
Maryland	Washington DC	National Indian Health Board (NIHB)	National Health advocacy for 560 Tribes: Policy, advocacy and coordination of voice
Maryland	Washington DC	National Council of Urban Indian Health (NCUIH)	National health advovacy for 30+ Urban indigenous health organisations
Maryland	Washington DC	Indian Health Service (IHS) HQ	Federal delivery system for Native Americans and Alaska Natives on-reservations
Maryland	Washington DC	Senate Committee on Indian Affairs (SCIA)	Political decision-making approaches to indigenous and health affairs
Nevada	Las Vegas	Evidence-Based Leadership (EBL) Conference	Using data to drive performance and oversight
New Mexico	Albuquerque	National Congress of American Indian (conference 2019)	560 tribal national governance body: generating a collective voice on national issues. Sovereign Immunity discussion
New York	Queens	Department of Health & Mental Hygiene (Health Equity Dept)	Taking a neighborhood approach to addressing equity in a metropolitan city
Ohio	Cleveland	Cleveland Clinic	International excellence; growing leadership in health care; equity approaches. 'Director of Diversity' position emphasis
Ohio	Cleveland	Global Center for Health Innovation	The shift in health technology from serving providers to serving patients
Ohio	Cleveland	Cuyahoga Health Improvement Project (Collective Impact)	Using Collective Impact to coordinate multi-agency approaches to high need communities
Ohio	Cleveland	Cleveland Leadership Center (CLC)	Creating a pipeline from school-age to grow civic leaders in a city like Cleveland
Oregon	Portland	North West Portland Area Indian Health Board (NWPIHB)	Coordinating 28 Tribal health activities to contribute to national agenda on health
Tennessee	Nashville	United South and Eastern Tribes (USET)	Using political advocacy and positioning to drive Treaty rights and obligations of Government. Highly organised
Washington State	Seattle	Seattle Indian Health Board (SIHB)	Patient accessible Health Records (online patient access) in an urban setting.

Site visits I have undertaken:

OBSERVATIONS / SITE VISITS

DATE YEAR	WHERE	EVENT	KEY FOCUS
1999	U.S. / Canada	WHO Fellowship	Governance of Health
2009 April	Spokane, Washington	TSG Conference	Affordable Care Act (Obamacare) – including ITU provisions
2010 May	Scottsdale, Arizona	TSG Conference	ACA implementation
2011		TSG Conference	3rd party collections
2012 May	New Orleans, LA	TSG Conference	Contract support costs; Capital Facility shortfalls
2013 May	Anaheim California	TSG Conference	California Rural Indian Health Board (CRIHB)
2014 May	Washington DC	TSG Conference	Academic partnerships: Third party billing – ACA
2015 April	Reno Nevada	TSG Conference	IHS Funding review report
	Northwest Portland Area Indian Health Board	Portland Oregon	Self-governing collective of 29 Tribes
	Alaska Native Tribal Health Consortium	Anchorage	Self-governing State-Wide Compact
	Seattle Indian Health Board (NCUIH)	Seattle	Urban Indian Center
2016 May	Orlando, Florida	TSG Conference	Contract Support Costs
	Seminole Tribe	Florida	Self-governing Tribe
	Washington DC	National Indian Health Board	National role
	Washington DC	National Council of Urban Indian Health	National role
	Washington DC	Senate Committee on Indian Affairs	Present most Bills to the House
2017 May	Spokane, Washington	TSG Conference	Political change (Obama/Trump) Health Information Technology
2017	Anchorage Alaska	NIHB Tribal Public Health Conference	Epidemic (Opioid)
	Kenaitze	Kenai Tribe	Self-governing Tribe
	Phoenix	Phoenix Indian Medical Center (PIMC)	IHS regional center
	Phoenix	Gila River site visit	Self-governing Tribe
	Washington DC	NIHB Meeting	National Advocacy
2018	Oklahoma	TSG Conference	30-year celebration
	United Southern and Eastern Tribes (USET)	Nashville	Self-governing collective entity for 27 Tribes

DATE YEAR	WHERE	EVENT	KEY FOCUS
2019 Oct	Albuquerque, NM	NCAI Conference *"Sovereignty in Action' theme aimed at celebrating the strength and contributions of Indian Country*	573 Tribal national entity since 1944 – big issue Census and Elections/Voting (U.S. and NCAI). Sovereign Immunity
	Navajo Nation	Various IHS sites	GIMC, Pinon, Chinle
	Navajo Nation	Tuba City Regional Health Corporation	Self-governing Navajo site

CONFERENCE	KEY ISSUES DISCUSSED
NIHB 34th National Tribal Health Conference: *United Tribal Voices Advocating for Healthy Native People* (Washington Sept 2017)	**Major Issues Presented / Discussed:** • Public Health issues: Zika virus, Opioid crisis, Mental Health and Addictions, National HIV/AIDs strategy • Revenue: Expanding Patient Care opportunities and maximizing 3rd party revenues; Medicaid expansion, IHS/Tribal Budget Formulation • Workforce development (DHAT) • Good Health and Wellness in Indian Country (GHWIC) report out from TECs. **2017 NIHB Policy and Legislative Priorities:** • Legislation: Preserve IHCA and Public Health provisions in the ACA; Preserve Medicaid protections for AI/AN; enact Special Suicide Program for AI/AN • Funding/Appropriation: Phase in full needs-based funding – enact mandatory and advance appropriations to IHS and increase appropriations (by other agencies) outside of IHS; seek long term renewal of SDPI • Capacity: Build capacity of Tribal Public Health; expand CHAP • System: Continue oversight and accountability of IHS; workforce development programs for Public Health and Indian health programs; expand access to AI/AN veterans • Policy: Expand Self-Governance to other agencies within the Department of Health and Human Services; preserve and expand Tribal Consultation policy. • Education: Continue education to Tribal members on Tribal Self-Governance. Sovereignty and Trust Responsibility.
NIHB 35th National Tribal Health Conference: *Tribal Unity to advance the promise of health* (Oklahoma)	• Systems Change through Law, Policy and Advocacy • Strengthening Medicare, Medicaid, and Health Systems • Enhancing Relationships between Tribal and State Governments • Native Youth: Making a Difference • Opioid, methamphetamine, suicide prevention and other Tribal Behavioral Health priorities.
2010 Tribal Self-Governance Annual Conference (May 2010) Scottsdale Arizona "*Self-Governance: The Path to Solutions*"	• Self-Governance training • Budget priorities; Contract Support Costs • Legislative updates (e.g., ACA); Health Care reform (ACA); reauthorizing the Indian Health Care Improvement Act • Health Information Technology – Meaningful Use; GPRA reporting.

CONFERENCE	KEY ISSUES DISCUSSED
2013 Tribal Self-Governance Strategy Session: Summary of Priorities, Washington DC (October 2013)	• Theme: Honoring the Treaties & Trust: Moving Self-Governance Forward • TSG Strategic Plan has three priorities: · Advance SG Policy, Budget and Legislative priorities · Strengthen Self-Governance Advocacy Efforts · Implement and Track Goals / Actions in the Strategic Plan.
2013 Tribal Self-Governance Annual Conference (April 2013), Anaheim California "*Strengthen, Advance and Invest in Self-Governance*"	• Self-Governance opportunities and training • IHS, TSG and Legislative update • IHS Budget strategy; maximizing 3rd party revenue; Contract Support Costs • Legislative update • Tribal Best Practices; Improving Patient Care initiative • Tribal Information Technology Systems; GPRA reporting.
2014: Tribal Self-Governance Annual Conference "*Self-Governance Nations with Voices and Choices*" (Arlington Virginia)	• White House Domestic Policy update • Centers for Medicare and Medicaid, and ACA Update • IHS, TSG and OTSG updates • Legislative and Budget Updates • Information Technology and Health Information Systems; medical records privacy • Native solutions for oral health.
Self-Governance Communication & Education Tribal Consortium: Annual 2016 Tribal Self-Governance Conference (Florida, April 2016)	• IHS Update and Office of Tribal Self-Governance update • Partnership IHS and Veterans Affairs • National TSG Strategic Plan & Legislative Update (e.g., ACA) • Behavioral Health, Diabetes, Alcohol and Substance Use prevention • Building a health workforce – recruitment and retention + Developing health professionals • Maximizing Revenue; paying Medicare-like rates for purchased or referred care; Calculating Contract Support Costs • Investing in Technology to support Tribal Health Systems and Quality Patient Care.
2017 Tribal Self-Governance Conference Annual Conference "Progressive Partnerships: Investing in Tribal Nation Building", Spokane	• Legislative update (115th Congress) • Workforce development partnerships with universities • Solutions to modernize Health Information Technology (introduction of MIPS – Merit Based Incentive Payment Systems) • Successful Tribal-State partnerships.
2017 NIHB National Tribal Public Health Summit (June 2017) Anchorage Alaska *Together We Rise: Sustaining Tribal Public Health as a National Priority*	• Public Health Policy, Infrastructure and Capacity: Public Health Innovations (and Awards) • Empowering Youth Wellness • Health Promotion and Disease Prevention (e.g., diabetes) • Substance Use and Mental Health • Climate Change and Environmental Health.

9.5. APPENDIX E: Literature Search Strings

PUBMED Search String:

((("American Indian"[Title/Abstract] OR "Native American"[Title/Abstract] OR "Alaska Native"[Title/Abstract] OR Indigenous[Title/Abstract] OR Tribe[Title/Abstract] OR Tribal[Title/Abstract] OR Native[Title/Abstract] OR "First Nations"[Title/Abstract] OR Aboriginal[Title/Abstract]) AND (Reservation[Title/Abstract] OR "Indian Health Service"[Title/Abstract] OR IHS[Title/Abstract] OR "Urban Indian"[Title/Abstract] OR "Tribal health"[Title/Abstract] OR "Indian Health"[Title/Abstract]) AND (USA[Title/Abstract] OR America[Title/Abstract] OR "United States"[Title/Abstract]) AND ("Self-Governance"[Title/Abstract] OR "Tribal governance"[Title/Abstract] OR "Tribal Self-Governance"[Title/Abstract] OR "Self-determination"[Title/Abstract] OR Sovereignty[Title/Abstract]) AND (Success[Title/Abstract] OR "Critical success factors"[Title/Abstract] OR Evaluation[Title/Abstract] OR Outcomes[Title/Abstract] OR Impact[Title/Abstract] OR Effectiveness[Title/Abstract])))

Yields 8 articles

Google Scholar Search String:

("American Indian" OR "Native American" OR "Alaska Native" OR Indigenous OR Tribe OR Tribal OR Native OR "First Nations" OR Aboriginal) AND (Reservation OR "Indian Health Service" OR IHS OR "Urban Indian" OR "Tribal health" OR "Indian Health") AND (USA OR America OR "United States") AND ("Self-Governance" OR "Tribal governance" OR "Tribal Self-

Governance" OR "Self-determination" OR Sovereignty) AND (Success OR "Critical success factors" OR Evaluation OR Outcomes OR Impact OR Effectiveness)

Yields 145 articles