DHHS Initiates National Search for New IHS Director

ROCKVILLE, M.D. — As rumors about the selection of the new Indian Health Service (IHS) Director persist in health centers and tribal offices throughout Indian country, the Department of Health and Human Services (DHHS) has announced that it will accept applications for the position until September 11.

Speculation about the choice for a new director started July 15 when Dr. Emery A. Johnson, IHS Director for the past 12 years, announced that he will retire September 1 (see related article pg. 8).

A number of prominent names have been suggested as possible replacements, including several highly respected Indian physicians and Indian health administrators. Several newspapers have also indicated that only a few "leading candidates" are actually being considered for the job. But according to DHHS officials, the field is still wide open and all qualified candidates will be considered.

In announcing Dr. Johnson's retirement, Assistant Secretary of Health Dr. Edward Brandt stated that he was seeking "a physician with a solid background in clinical and community medicine" to fill the position.

However, in a later meeting with several Indian leaders, Brandt stated that consideration would not be limited to physicians, and that candidates with degrees in health sciences or allied sciences will be considered.

According to Elwood Saganey, chairman of the National Indian Health Board, who attended the meeting with Brandt, an agreement was also reached to advertise the position nationally; consider all qualified applicants; attempt to fill the directorship within 90 days; and apply Indian preference law in the hiring process.

In keeping with this agreement, the Public Health Service (PHS) released a job announcement August 17 and distributed it across the country. The position is designated as a Senior Executive Service vacancy, and the selectee will be required to meet security clearance requirements.

Specifically, the PHS notice sets forth the mandatory professional and managerial qualifications for the position. Minimum professional requirements include "demonstrated senior level experience in the management and administration of health care services," and "proven professional competence in a health, medical, or allied health science area." Managerial qualifications include "experience which demonstrates leadership and managerial ability including program planning, budgeting, program coordination or administrative management of health care delivery programs or health related programs."

According to the announcement, qualified applicants will be evaluated by a panel of specialists. The announcement also stipulates that preference will be given to qualified Indian applicants.

The individual selected for the position will assume responsibility for the total management of the Indian Health Service program, which employs approximately 10,700 persons and has an operating budget of $635 million. The program provides health care services to more than 700,000 American Indians and Alaska Natives nationwide.

Brandt has indicated that he hopes to fill the position by mid-October. In the meantime, Dr. Joseph Exendine, IHS Deputy Director, has been named acting administrator of the agency.
Health News Across the Nation

The following is a regular feature of the NIHB Health Reporter. In this section, we present our readers with short briefs on issues and activities from around the country that are related to Indian health care, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on items mentioned here can be obtained from the NIHB Public Information Office.

BILLINGS, MONT. — Interior Assistant Secretary Ken Smith told attendees of the National Tribal Chairmen’s Association (NTCA) ninth annual meeting here that he has been named chairman of a Cabinet Council working group that will be responsible for developing an Indian policy for the Reagan Administration. Working with Smith on the Indian policy group will be representatives from Health and Human Services, Justice, Agriculture, HUD, Education, and Labor. Robert Carleson, special assistant to the President for policy development, will be the White House link for the group.

FORT COLLINS, COLO. — The National Indian Health Board (NIHB) Science Center has submitted a grant proposal to the National Science Foundation to examine ethical issues in scientific studies of Native American communities. The purpose of the grant is to study how scientific endeavors have been carried out in four tribal communities, and to determine how scientific studies have affected those tribes. The project will also examine how information obtained from such studies has affected federal policy toward American Indians and Alaska Natives. Funding for the project will begin September 15. Any tribal council or chairman’s office interested in participating in this project should contact: Director, NIHB Science Center; Department of Food Science and Nutrition; Colorado State University; Fort Collins, Colo. 80523.

STEWART, NEVADA — Dedication ceremonies were held here June 20 for the opening of the Wa-Newe-Numa alcohol and drug abuse treatment center and the Wa-Pai-Shone youth home for girls. The dedication was attended by Nevada Governor Robert List and tribal officials from throughout the state. Inter-Tribal Council of Nevada Executive Board Chairman Davis Gonzales stated “I’m especially proud of these endeavors because they represent the first Indian program of its kind in the state.” Clients at the alcohol treatment center participate in a variety of counseling programs on a daily and weekly basis, both inside and outside the facility. Vitamin therapy and anti-alcohol agents are used, and the treatment emphasis is on determining what causes lead to an individual’s abuse of alcohol or drugs, and how the individual can be helped to deal with those factors in the future.

DENVER, COLO. — Tribal councils from the Southern Ute and Ute Mountain Tribes recently took part in an agreement with the Colorado State Department of Social Services permitting Colorado Indian tribes to handle Indian child welfare cases in state courts. Under the agreement, a child being considered for foster care in a state court is an Indian, the state has an obligation to contact the child’s tribe to determine whether the tribe would prefer to transfer jurisdiction to a tribal court. Southern Ute Tribal Chairman Leonard Burch stated that “I am pleased and proud the Tribal Council has worked out an agreement with the state that will result in our ability to take care of our children.”

PHOENIX, ARIZ. — The Phoenix Service Unit Indian Health Advisory Board is seeking applicants for the position of executive director with the organization. Applicants should have a master’s degree in a health related field, and four years experience in health related organizations, program planning, or business administration. Starting salary is $26,432 per annum. To apply, submit resumes by September 25 to: Phoenix Service Unit Indian Health Advisory Board; 4201 N. 16th St., Suite 260; Phoenix, Ariz. 85016.

GRAND FORKS, N.D. — The Indians Into Medicine Program (INMED) reports that the number of new INMED scholarships distributed this fall has been greatly reduced. Only four out of 20 new applicants received scholarships for this year, said Manny King of INMED. A total of 39 students will receive scholarship support, with no freshmen enrolled in the Fall program,” said King.

OAKLAND, CALIF. — After a three-year effort, the California Urban Indian Health Council has completed preparation of the California Indian Maternal and Child Health Plan. The plan identifies six major priorities for services: incidence of late or no prenatal care among Indian women; lack of complete and reliable data regarding Indian maternal and child health; high risk for fetal alcohol syndrome; high alcohol mortality for Indian youth aged 15-24; lack of cultural sensitivity among mainstream providers; and Indian family upheaval. Copies of the plan can be obtained from CUIHC; 1615 Broadway; Oakland, Calif. 94612.

TUCSON, ARIZ. — Dr. E. Stuart Rabeau, director of the IHS Office of Research and Development here since 1969, recently announced his retirement from active service. Rabeau, who served with IHS for 35 years, has accepted a position as a state health officer in Alaska.

WASHINGTON, D.C. — The President’s Committee on Employment of the Handicapped has free information — including posters and materials for classroom use — promoting an understanding of the handicapped. For additional information, contact: the President’s Committee on Employment of the Handicapped; Vanguard Building, Room 600; 111-20th St., N.W.; Washington, D.C. 20201. Phone (202) 653-5044.
SELLS, ARIZ. — Driving down Highway 86 inside the Papago Reservation you may pass a truck with a bumper sticker that reads, "Happiness is a Breast Fed Baby." Or while doing business at the reservation's capitol here, you may be surprised to hear the cooing of contented babies coming from a room in the administrative complex building that has been converted into a nursery.

This unique emphasis on breastfeeding among the Papagos, a tribe of 10,000 people located in Southern Arizona, is the result of an 18-month initiative to bring back the traditional way of infant feeding — breastfeeding.

The results of the Papago Model Breastfeeding Education Project are "outstanding," says project director Judy Sedolo. "I have not heard of a more comprehensive and innovative breastfeeding project anywhere."

According to Sedolo, over the last year-and-a-half the Papago Tribe has been developing this educational project for Papago mothers and their families. The project was prompted by the realization that there had been a significant decrease in mothers choosing to breastfeed their babies and a concurrent trend toward bottlefeeding. And according to numerous tribal nutritionists and hospital personnel, there still were too many cases of infant diarrhea (the most severe type), susceptibility to infections, ear aches and dental problems appearing among the infants that could be directly related to the rise in bottlefeeding.

But, according to Sedolo, one of the most important reasons for promoting breastfeeding was the continued high incidence of diarrhea. "Diarrhea has been a killer of Indian infants," said Sedolo. "The lack of care in covering the baby's bottles and the danger of contaminated water and spoilage also increased the chances of continued infections and diarrhea."

With their plan of attack underway and a major effort to provide the benefits of natural protection from disease, decreased risk of diarrhea, better dental health, added bonding between mother and child, and the provision of the best nutrition possible, the tribe and other major health agencies joined forces to reverse the trend of bottlefeeding and promote breastfeeding on the reservation.

The project, which was made possible through a $68,000 grant from the U.S. Department of Agriculture, used a coordinated team approach with six other health agencies serving the Papagos. These included the Papago Disease Control Program, the Community Health Representatives, the Community Health Nurses, Freedom from Hunger Foundation, as well as the Papago Nutrition Improvement Program. A representative of the La Leche League International has served on the advisory team, and the help of many others has contributed to the project, said Sedolo.

The services provided by the project were comprehensive. "Educational workshops have been held in village communities to enable the whole community to learn more about breastfeeding and become involved. A breastfeeding helper has been trained to provide mothers with prenatal counseling and after the mother and baby come home from the hospital, the helper visits them at home to offer advice and support," Sedolo said.

Besides all medical and health staff having had the advantage of special training in the area of breastfeeding and infant health, a special breastfeeding nursery for babies from birth to six months was also provided. The nursery was especially designed for mothers who have returned to work or school, said Sedolo, and was conveniently located only two blocks from the tribal administrative offices, enabling new mothers to breastfeed their babies at least three times during each eight-hour workday.

A reservation-wide survey of current and past infant feeding practices has also been done in order to design an effectual education effort and to gauge the impact of the project, said Sedolo.

"We are still tabulating final figures of the survey, but out of our present sample group of the project's breastfeeding mothers and infants and non-breastfeeding mothers and infants, there has been a major change in values, attitudes and infant feeding practices. According to the survey, before the project began, there were approximately 23 percent of the new mothers who breastfed their babies. By the end of the project, this percentage had increased 20 to 44 percent," said Sedolo.

Continued on Page 5
DENVER, COLO. — Because of the near epidemic proportions of alcoholism among American Indian and Alaskan Native populations, members of the Association of American Indian Physicians (AAIP) devoted their 10th annual meeting here July 22-25 toward developing strategies for combating the disease.

The meeting provided a comprehensive review of recent advances in the understanding of alcoholism and its management, especially as these relate to Indian people. An in-depth look into the biochemical effects of alcohol on human cells and tissues as well as presentations on various alcoholism programs designed for Indian people were given.

The majority of the meeting's presentations were clinical in nature and focused in areas concerning alcohol brain damage and cognitive functioning; genetic variability in responses to alcohol; surgical implications of chronic alcoholism; biological markers for alcoholism; and the medical and social variables of fetal alcohol syndrome.

The intent of the meeting, according to AAIP Executive Director Bill Wilson, was to help acquaint the participants with new research information and to help set new research priorities and directions in the area of alcoholism and how it relates to Indian people.

Much attention has been focused on the increased biological research that is being generated in the field of alcoholism, says Dr. Everett Rhoades, former president of AAIP. "I am excited about the fact that knowledge is increasing in the field of alcoholism, especially in the area of biological markers and fetal alcohol syndrome," said Rhoades.

Looking at the past, present and future of Indian alcoholism programs, Dr. Emery Johnson, Director of the Indian Health Service (IHS), said that the physicians have a great deal of influence in this country over what goes on in their communities. "Doctors should try," said Johnson, "to help their community design and manage itself in such a way so that it will minimize the potential for children and adults getting into alcoholism."

Johnson also stated that the problem of alcoholism will not be solved by traditional methods of treatment. "The solutions are not totally here and we are a long way from solving the alcohol problem. Doctors are not going to fix the problem of Indian alcoholism. Human services has more to contribute to the area than doctors, especially in the area of intervention," said Johnson.

In the clinical presentations, Dr. Arthur Zeiner, professor in the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma College of Medicine, presented several case studies that indicate there might be a genetic biological marker for alcoholism. The marker may be in the form of an enzyme called "acetaldehyde," the first metabolic product of ethyl alcohol, said Zeiner.

"At the present time we really don't know what causes alcoholism," Zeiner said, "but we are looking at possible biological factors." According to Zeiner, some biological evidences have already appeared from three sources: Families (four times the risk of becoming an alcoholic if children have alcoholic parents); body metabolism (how the body metabolizes alcohol could provide a biological marker); and higher levels of acetaldehyde present in alcoholics as compared to social drinkers.

Zeiner also stressed that a definite plan of research in the Indian communities needs to be established in order to adequately address the problem of Indian alcoholism.

Research in alcoholism has also produced studies in genetic variability responses to alcohol. Dr. Ting-Kai Li of

Continued on Page 5
**Unique Papago . . .**  
*Continued from Page 3*

The survey is also showing that the diarrhea rate of the bottlefed babies was four times the rate of the breastfed babies and that 60-65 percent of the bottlefed babies had numerous ear infections, way over the incidence of ear infections for breastfed babies.

"We will continue to encourage breastfeeding and to encourage more and more mothers who don't have or know about the option to breastfeed. We feel the economic and health benefits far outweigh the bottlefeeding option," said Sedolo.

Present survey statistics also indicate that 87 percent of the reservation's population prefers breastfeeding. "This is a great deal higher than the national average," beamed Sedolo.

Continued funding of the project will come from the tribe with new mini-nursing nurseries in the works as well as the further development of Papago-oriented educational materials created for use in counseling mothers and increasing public awareness.

**Indian Doctors . . .**  
*Continued from Page 4*

the Indiana University Medical Center presented information from studies on animals that indicated some forms of drinking behavior are genetically determined. Ting-Kai Li said that the animals demonstrated evidence of varying metabolic tolerances and physical dependency to alcohol.

Ting-Kai Li said that he believes there is a genetic influence in the susceptibility to alcohol; that genetics may cause variables in alcohol metabolism; and that humans demonstrate a wide variety of alcohol metabolism capacity. "In the experimental animals, all exhibit a genetic tendency toward alcohol, but there has not been enough studies on humans to make a positive statement to that effect. Genetic and enzyme determinations still need further study and correlations between ethnic groups," said Ting-Kai Li.

Another area that cited the extreme dangers and hazards that could come from alcoholism was discussed by Dr. Philip May, the director of the Fetal Alcohol Syndrome Project, IHS, in Albuquerque. Dr. May reviewed some of the effects of fetal alcohol syndrome, including mental retardation, growth deficiencies and distinctive facial features. Slides were shown of children with club feet, cleft lips, facial distortions, poor coordination and distorted heads and faces.

According to May, it has only been in the last seven years that fetal alcohol syndrome has been properly dealt with on Indian reservations. Before that many of the children and some adults with the syndrome were placed in mental institutions or were diagnosed incorrectly.

Heavy drinking during pregnancy causes the syndrome, said May. "Six to 10 drinks a day will affect the fetus. Even light drinking of one ounce of alcohol a day can produce low birth weights and increased risks of spontaneous abortions," he added.

Two and one-half years ago IHS started a fetal alcohol syndrome pilot program on the Navajo reservation. The program provided for the training of IHS service unit personnel in detecting fetal alcohol syndrome and setting up clinics that could help children with the syndrome, said May.

The program has worked with over 200 children so far, said May, and 73 percent have been placed in foster homes. "Most of these kids' mothers died either from trauma or cirrhosis of the liver," said May.

In the closing presentation, George Hawkins, executive director of the National Indian Board on Alcohol and Drug Abuse, said that it will take the dedication and honesty of the doctors to help fight the problem of Indian alcoholism.

"I have been involved in alcoholism for 54 years," said Hawkins, "40 of those years I was drinking. It is never too late to seek treatment," Hawkins said.
Notes From the Executive Director:

“This Indian Health Service (IHS), in its role as the primary provider of health services for American Indians and Alaska Natives, is the largest single provider of public health programs in the nation.”

This is a direct quote from a report on the management of the Indian Health Service which was prepared by the staff of the Office of the Inspector General, Department of Health and Human Services, published as draft report in March, 1980.

The information depicted in the above referenced report is most enlightening. I shall endeavor to “whet your appetite” and encourage you to request your personal copy of this report in my column this month.

It is most ironic when you compare the numerous Resolutions adopted by Tribes, Indian organizations, Area Health Boards and the National Indian Health Board, all reflect many of the same problems enunciated in the Inspector General’s report.

We have reviewed not only this report, but also the General Accounting Office (GAO) report as well as Task Force #6 report and the Final Report of the American Indian Policy Review Commission, along with studying the U.S. Senate Select Committee on Indian Affairs oversight hearings and we find they all recommend practically the same things.

Those of us involved in a common goal of helping IHS fulfill its mission should be most knowledgeable about its problems and the possible solutions. We will get nowhere by just continuing to complain about poor quality of service, lack of funding, too many demands, apparent lack of interest, and all the many other complaints registered.

Isn’t it about time that we all began working side by side, shoulder to shoulder, face to face, and start resolving our problems? Each of us have a job to do. It makes no difference whether we are in management, direct delivery of health services, Tribal administration or whether we are a consumer of the end product. We all have the responsibility of improving our service everyday.

The Inspector General report, as referenced above, spells it out quite thoroughly in its overview section. It states that their “overall impression of the Indian Health Service is that it is a classic example of an organization that tries to be all things to all people, IHS suffers from a number of management problems such as conflicting goals, lack of priorities, poor communications, and other serious problems — indeed, we find that presently the IHS has neither the staff, management systems, nor resources to succeed.”

The report further states: “We have observed hard working, devoted and competent staff trying desperately, under difficult conditions, to keep up with the needs of Indian people. This is particularly true at IHS Service Units and on the reservation. The fact that IHS staff succeed more often than not is a greater tribute to their real concern and motivation than it is to their management skills.”

That portion of the report which enlightened the real situation stated:

“We also want to emphasize our impression that although there is genuine concern and interest for IHS within Public Health Service and the Department (HHS), there is little visible evidence of an understanding and appreciation for the difficulties faced by IHS, or of the unique public health opportunities IHS presents. In many ways IHS is as remote from the support and assistance of the Washington bureaucracy as is the most isolated Indian Tribe.”

newest and most difficult responsibilities on the basis of very little data. This is particularly true in the area of self-determination. The failure to collect data on IHS performance and potential and to provide this information to the Congress should be attributed to the Department. IHS is well aware of the fact that it needs adequate data in order to efficiently manage its resources and to account to the taxpayer, the Congress, and to the Indian people.”

“IHS has many important goals: Assisting tribal leadership in planning and operating health care systems; training and hiring skilled Indian professionals; acting as a principal federal advocate for Indian people; and delivering or arranging for the delivery of high quality comprehensive health services to American Indians.

“Should the health services delivery be allocated seventy percent of IHS funds and staff? Sixty percent...with the other forty percent going to implementation of self-determination? In view of IHS’s present staff and budget

Continued on Page 7

NATIONAL INDIAN HEALTH BOARD
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NIHB Reviews Contracting Issues, Adopts Conference Resolutions

OKLAHOMA CITY, OKLA. — Problems with federal contract negotiations, program cutbacks, and the implications of the Administration's block grant program are among the major problems affecting area Indian health boards, according to representatives of the National Indian Health Board (NIHB). These and other concerns were raised during the board's regular quarterly meeting here June 28-July 3.

Portland area representative Mel Sampson stated that the Northwest Portland Area Indian Health board (NPAIHB), which he chairs, "will have to have several programs funded by other means, or they will have to be eliminated."

NPAIHB is seeking funding to continue its work in the areas of health education, research, program analysis, and the board's newsletter, Sampson said. The board is also attempting to develop an environmental health component "because of the level of nuclear energy activity in the Northwest," he said.

Sampson added that the Administration's health block grants are potentially devastating to tribal health care programs, since Indian reservations have limited economic alternatives to the present funding.

To address some of these concerns, Sampson continued, NPAIHB has recommended that the IHS budget be increased to the level requested by the Carter Administration, and that present efforts to close the Public Health Service hospital in Seattle be halted. Sampson explained that the Portland area has no IHS hospital, and Indian patients must rely on the Seattle PHS hospital for referrals. "Without the PHS hospital, Indian people will have to use private hospitals, which cost a great deal more under contract care," he said.

Timm Williams, NIHB California representative and chairman of the California Rural Indian Health Board (CRIHB), reported that the major difficulty for Indian health projects in his area centers around contract with IHS and other agencies to provide a wide range of health care services to Indian people in California, Williams said.

One particular problem involves CRIHB's eligibility to contract under the authority of P.L. 93-638, the Indian Self-Determination Act. Williams explained that because several CRIHB board representatives are not federally-recognized tribal members, IHS has determined that the organization does not meet legal requirements for contracting under P.L. 93-638.

CRIHB, on the other hand, contends that it is a tribal organization eligible for such contracts. "Our stand is that the Indian community recognizes these board members as Indian people. Who has the right to determine whether or not these people are Indians?" Williams asked.

Continued on Page 11

Notes From . . .

Continued from Page 6

limitations there is no doubt that one or the other of these goals must receive a lower priority. IHS must honestly and fearlessly ask itself what it can reasonably expect to achieve within a given level of resources.

"These are difficult choices, but until IHS, the Congress, and the Indian people can reach a reasonable determination on the relative value of each of IHS's priorities, there is little hope that funds, staff and management attention will be allocated in any manner which approximates the importance of the objective to be achieved.

"It is our impression, however, that staff and dollars will still be too short to come close to meeting most of the important goals set for IHS by the Congress."

Very shortly IHS will begin developing their budget request for FY'84. Tribes must get involved with their Service Unit Director and develop the budget request for their health delivery at the Service Unit as well as at the Area.

NIHB feels that we will never reach resolution of our health delivery problems until all our Tribal governing bodies understand the IHS budget process. We must know the problems as well as how our monies are developed and expended. Without this knowledge, we cannot establish goals and priorities.

We need each of you to become deeply involved. If you are serving as an elected Tribal official, you should work to become involved in developing the budget that provides for health services to your people. In September, October, November, and December, this budget will be developed, and NIHB will keep you informed as to its progress.

See you next month! ■

J.W.

NARCISSUS GAYTON (left), NIHB representative from Albuquerque, confers with Dr. Alan Ackerman (right) following his presentation at the board's quarterly board meeting in Oklahoma City last month. Ackerman reported that the NIHB Science Center has completed publication of health education materials in the areas of diabetes, breastfeeding, and traditional foods and that the materials are now available for sale.
Dr. Emery A. Johnson, Assistant Surgeon General and Director of the Indian Health Service (IHS) for the past 12 years, recently announced that he will retire from his position on September 1. The Department of Health and Human Services is currently conducting a search for a new IHS Director (see article pg. 1).

During Dr. Johnson's career, and particularly during his tenure as IHS Director, the nature of the IHS program and the health care status of Indian people have changed dramatically. Dr. Edward Brandt, Jr., Assistant Secretary of Health, in announcing Dr. Johnson's retirement, stated that he "has left a legacy that will be hard put to improve." NIHB Executive Director Jake Whitecrow noted that "Dr. Johnson has been a driving force in the improvement of the health status of American Indians and Alaska Natives. The Indian Community is going to miss him very much."

Because of his unique perspective of the Indian health program, we asked Dr. Johnson to comment on some of his experiences in the field of Indian health care over the last 25 years. In the first segment of this interview, Dr. Johnson describes some of his early experiences as a reservation doctor, and how those experiences helped influence his views on community medicine. In the second part of the interview, which will appear in next month's issue, Dr. Johnson discusses some of the present and future directions of Indian health care programs.

Dr. Johnson received his medical degree from the University of Minnesota in 1954 and joined the Indian Health Service in 1955 as a medical officer at the PHS Indian Hospital in White Earth, Minnesota. He served as Medical Officer in Charge at White Earth (1956-57); Winnebago, Nebraska (1957-59); and the Phoenix Indian Medical center in Phoenix, Arizona (1961-63) before being appointed Area Director for the Billings, Montana IHS office (1964-66). In 1966, Dr. Johnson was assigned to IHS headquarters as Chief, Office of Program Services. He was promoted to the position of Deputy Director in 1967, and became the Director of IHS in 1969.

Dr. Johnson has worked with numerous medical associations and governmental committees. He has also received many awards, including the PHS Distinguished Service Medal; the Award of Merit from the Association of American Indian Physicians; the Award for Outstanding Leadership from the National Tribal Chairmen's Association; and the Rockefeller Public Service Award.

HEALTH REPORTER: How did you first get involved in the provision of health care to Indian people?

JOHNSON: Back in 1955 every able bodied graduate from medical school was required to provide two years of service. I had a friend who had taken a surgical fellowship at the Mayo Clinic and he went into the army and spent two years doing physicals on draftees. I thought that was a terrible way to waste a medical education, so I was looking for some way to fulfill my service obligation and also practice medicine.

The Public Health Service came to the hospital where I was in training one day and I asked if they could guarantee...
Indian Health Status, Highlights of 25 Year IHS Career

me a clinical assignment if I joined. They said, "well, of course," so I said, "where do I sign?" So I signed up for my two years of service with absolutely no intention of spending a career in Indian Health.

HEALTH REPORTER: So you started in 1955 as a medical officer at the White Earth Reservation hospital in Minnesota; what was the program like at that time?

JOHNSON: The White Earth hospital was a wooden frambuilding that was built about 1912. It had a couple of big wards, a small square room with a couple of cribs, and a small labor room and delivery room across the hall from each other. There was an operating room that opened directly off the main lobby on one side and into a ward on the other.

We had a laboratory that consisted of an old monocular microscope and that was it. We couldn't do a blood count or any chemistries. We did hemoglobin by the Tahlquist method, which will only tell you if a patient has blood, and it was essentially a useless procedure. We had a fairly good X-ray machine but there was no technician, so one of the first things we had to do was learn how to take X-rays and develop them ourselves, which we did. We had a very limited supply of drugs. There was barely enough nursing staff to cover the shifts and only one clerk who took care of medical records and all of the management. As a result, I learned how to keep books.

Our dental clinic was down in the basement and we had one room that was probably 8' by 10'. In the center was an old broken down dental chair that was given to us by a private dentist who had thrown it out, and we had a foot operated dental drill and galvanized bucket to spit. The dentist came once a year for perhaps six weeks, and we had one dentist that covered Minnesota, Wisconsin and Iowa. The rest of the year I would have to take care of the dental problems, primarily by relieving pain and pulling teeth. In that same room we had our dispensary for drugs, our laboratory, the microscope, and a sink. That was the quality of stuff that we had to deal with.

HEALTH REPORTER: Would you say this was typical of Indian health clinics at that time?

JOHNSON: Yes, it was probably a fair assessment of many of the Indian Health Service facilities then. There was a whole series of imperatives that had to be put in place before changing the health status of the community. For example, you knew right from the very beginning, the first day, that diarrhea was a terrible thing and until you could get a handle on the water problem you weren't going to do much about treating diarrhea. Housing, sanitation and activities like that are important. The problems were not only totally inadequate physical facilities, equipment, and support staff, but there was no preventative program or mechanism to deal with the community patients. So it was crisis management every day. When I said I wanted a place to practice medicine, I sure got it.

HEALTH REPORTER: What was the most severe health problem in the Indian community at that time?

JOHNSON: I think the most obvious thing in 1955 was the tremendous infant mortality. Diarrhea and pneumonia were the primary causes of it. We had an infant mortality rate of something like 62 per 1,000 live births. In the general population at that time it was around 25 per 1,000.

HEALTH REPORTER: What steps were being taken to reduce the infant mortality rate?

JOHNSON: The acceptance of the program was probably the most critical thing that had to be done early. And the felt needs of the community are really the key to acceptance. People are not going to accept something they think is of no value to them, or that is an imposition or annoyance. So you have to go back to what it is the community really wants. What it seemed to me that the community really wanted was their babies to stop dying. Very simple. So what do you do to help keep babies from dying? Well, the first thing is to try to save them when their mothers brought them in. And having done that, we were then in a position to help the mothers understand what they can do to keep them from getting sick.

In San Carlos, for example, a decision was made that every infant with diarrhea would be hospitalized, whether they needed it or not. Remember, diarrhea was a great killer of Indian babies at that time. So the baby would be brought in and hospitalized. If he or she wasn't very sick, we would have the mother come back the next day and tell her that she brought her baby in early and he's now ready to go home. And the mothers would see these other babies who were brought in late and were very sick, and who were strapped down with tubes running into their heads. Over a period of a few months, the message in the community was that if you wanted to keep your baby from dying, when he begins to get sick, bring him in to the doctor.

So the dynamics of the mothers' perception of why you brought the kids to the doctor changed. The idea at one time was not to go to the doctor until all is lost. As a physician, to get a baby in that condition is a terrible thing to deal with. But you don't solve that problem by haranguing the mother and making her feel more guilty, because that will tend to drive her farther away. So we had to figure out what to do to change her concept of why she should bring the baby to the doctor.

It was necessary, in my judgment, to put a lot of stress Continued on Page 10
JOHNSON: While I was at Winnebago, we had a terrible problem with tuberculosis. We had a tremendous number of active cases of tuberculosis on both the Winnebago and Omaha reservations. And of course you'll never do anything with tuberculosis when you have open disease just rampant. If the patient won't undergo treatment for the disease there is not much the doctor can do. I approached the tribal councils about this and they said that they would take care of it. They finally came to the conclusion that yes, tuberculosis was terrible — the kids and babies would get sick and die, we'd have meningitis and other disease. So they passed a tribal resolution that prohibited those with tuberculosis from participating in tribal affairs. In other words, they couldn't go to the hand games, the council meetings, and things like that.

I'll never forget the Saturday morning after that, one of the councilmen came to my house and we talked. I couldn't understand what he was really up to, and finally he said: "My wife wants to go to the sanitarium." So she went and in those days you had to stay for a long time. But she stayed and got her treatment and came back.

The pressure was such that he and his wife knew that to be a part of that community that she had to get her TB taken care of. Within a year, we didn't have a single case of TB on either reservation that wasn't under approved treatment. Now the doctors could have sat in the clinic until hell froze over and ranted and raved about the need for treatment, but when the community made a decision that they had to do something about that problem then things got done.

So early in my career I had some experiences where it really proved to me that when the community decided to get involved in something, then it would help. I learned that just the doctors and nurses weren't going to fix problems. I feel lucky that I was assigned to reservations where we had the opportunity for this kind of experience.

HEALTH REPORTER: Was it part of IHS policy at that time to have the community actively involved in the treatment of tuberculosis?

JOHNSON: In Alaska there was a plan that was designed in part by the national office. A native in each of the villages, who were called chemotherapy aides, was taught how to provide treatment to the people in the village, and we treated entire villages that way. That's what stopped the epidemic of tuberculosis in Alaska, where there was the highest incidence of TB ever recorded in the world in the 1960s. There wasn't a Native family in Alaska that wasn't touched by tuberculosis. A few years ago I had the pleasure of being at the celebration where we closed the last tuberculosis service in Alaska. It was done, in part, by community action.

HEALTH REPORTER: That sounds similar to the present Community Health Aide Program in Alaska.

JOHNSON: The community health aides in Alaska are really the descendents of those old village chemotherapy aides. These chemotherapy aides learned something about health so the people in the village would come to them for other things. So, in the late sixties and early seventies we tried to make that formal. We trained...
somebody in the village to actually diagnose and treat all diseases, not just the TB. In Alaska, if you look at the statistics, the improvement in infant mortality, maternal mortality, and other things have changed dramatically. To a substantial degree, it is because of those village health aides who’ve been trained to diagnose and treat illness.

There was a study done by the World Health Organization two or three years ago by a professor at the Institute for Social Medicine in Sweden. He looked at the health programs in the Arctic region and concluded that there was no question that the best health program for nomadic people in that area was the one in Alaska. It’s based on the concept that local people can in fact care for themselves rather than having a doctor sitting in every little village.

**HEALTH REPORTER:** Was the same kind of concept used to start the CHR (Community Health Representative) Program?

**JOHNSON:** The project that really turned out to be the model for the CHR program was done at Northern Cheyenne in Montana when I was the area director out there. We went to John Wooden Legs, who was then the president of the Northern Cheyenne, and said: “This should be a tribal program. You select the people you want and we’ll train them so you can get them back and supervise them as tribal employees.” Then we did all the bureaucratic things and set the criteria for selecting the CHR’s. We set such requirements as having to be a high school graduate.

But the tribe selected people who hadn’t even gone to high school. What John Wooden Legs did shows the wisdom of the tribes. See, what we were proposing was imitation white man, and John was saying that he needed someone who could communicate with his people. From that the program has developed to where the tribes now select their CHR’s and we don’t even train them. Many times the tribes do the training.

The CHR program has been the mechanism in several things. First of all, it put some qualified health people under the control of tribal government. Before that, all the expertise was with the federal government. It also served as a mechanism to clearly change the understanding, both of the community and of the health professions, as to what was going on in the provision of health care services. From that, the CHR’s went on to become the foundation for tribal health departments or health authorities. And that was six to seven years before we had so-called Indian self-determination.

(End of Part I. Part II of the interview will appear in our next issue)

**NIHB Reviews . . .**

Continued from Page 7

not these people are Indian — the federal government or the Indian communities?” Williams asked.

CRIHB has exhausted all administrative channels to have the IHS decision overturned, and recently filed suit in federal district court on the issue, he said.

Contracting for health programs has also been a problem for the Papago tribe because of the uncertainty of funding levels and the lack of appropriate timeframes for negotiations, according to NIHB Tucson representative Muriel Ortegas.

Through its Executive Health Staff, the Papago tribe contracts for a number of health services, including programs for disease control; nutrition; mental health; services for the elderly; environmental health; alcoholism and drug abuse; and Community Health Representatives, Ortegas said. She also expressed her tribe’s concern over the lack of adequate IHS contract care funds for specialized health services.

In the United South and Eastern Tribes (USET) area, all of the tribes except for the Eastern Band of Cherokees contract under P.L. 93-638 for a least a portion of their tribal health programs, according to NIHB USET representative Maxine Dixon. Tribes in her area are concerned about negotiating adequate indirect cost rates in their health contracts, she said.

USET tribal health directors are also forming their own association in an effort to improve communication with tribal chiefs, Dixon said.

Elwood Saganey, NIHB Chairman and representative from the Navajo Nation, stated that the Navajo IHS area office has been functioning smoothly under Acting Director Dr. John Porvaznik.

Continued on Page 12
Alcoholism Program Initiatives Reviewed at NIBADA Meeting

DENVER, COLO. — Over 75 people gathered at the Eighth Annual meeting of the National Indian Board on Alcohol and Drug Abuse (NIBADA) here Aug. 11-14 to discuss alcohol abuse programming, prevention and funding alternatives.

According to President George Hawkins, NIBADA will continue to encourage the Indian Health Service (IHS) and other health organizations to seek specially earmarked monies for Indian alcoholism programs rather than going the route of the Administration’s proposed block grant funding.

Besides promoting the categorical funding alternative, NIBADA will also encourage the development of a National Indian Advisory Council on Alcohol and Drug Abuse, said Hawkins, and continue to encourage the establishment of an increased accreditation of Indian alcohol and drug programs. “We want to establish our own standards of accreditation because of the uniqueness of the programs,” said Hawkins.

NIBADA, established in 1973 by a group of recovered Indian alcoholics, has remained a strong advocate for Indian alcoholism and has been influential in shaping important events in Indian alcoholism program and funding for the last decade, said Hawkins.

Future directions of the organization were also addressed at the meeting. According to Hawkins, the organization will continue to increase tribal government’s awareness of the alcohol problems and the lack of adequate treatment programs.

“We are also working with the National Congress of American Indians (NCAI) and IHS in an effort to develop a programmatic study that will help develop an ideal service system,” said Hawkins.

Other national Indian organizations such as the National Indian Health Board and the Association of American Indian Physicians will also be involved in determining an ideal service system and budget base, he added.

Hawkins also said that the problem of alcoholism is still viewed as a moral problem and is not accepted as a disease. NIBADA is interested in utilizing more medical personnel in an effort to help treat the problem, he stated.

In the prevention area, “we still don’t know what to prevent,” said Hawkins. “The family unit is still the best classroom for educating the children.”
NIHB Reviews . . .

Continued from Page 12

The board also heard from Dr. Alan Ackerman, director of the NIHB Science Center in Fort Collins, Colo. Ackerman told board members that health education materials, in the form of taped radio plays and illustrated booklets, have been prepared and are available for sale. The materials, which address the nutritional aspects of breastfeeding, diabetes, and traditional foods, are designed for use in tribal health centers, Community Health Representative programs, seminars, and community settings.

In other business, the board took action on resolutions presented at the Fourth National Indian/Alaska Native Health Conference in San Diego, Calif., April 7-10. More than 100 individual resolutions were submitted for the Board's action during the conference. Those resolutions were subsequently consolidated into about 30 issue areas, with the board adopting the following resolutions:

- requesting increased funding for health facility construction at White Earth, Minn.; Shiprock, N.M.; Browning, Mont.; Ketchikan, Alaska; and Crownpoint, N.M., and for staff housing for the new health center in Chinle, Ariz.;
- requesting that confined funding be made available for sanitation facilities construction on Indian Reservations.
- recommending full funding for the Indian health scholarship program under Title I of the Indian Health Care Improvement Act;
- supporting NIHB testimony regarding the Administration's proposed budget for the Indian health programs;
- requesting that IHS work toward increasing the number of qualified Indian administrators in management positions within the agency;
- requesting that NIHB establish a Mental Health/Suicide Prevention Subcommittee to examine the problem of suicide among Indian populations and to recommend directions for suicide prevention programs on Indian reservations;
- requesting congressional hearings on the problems of the elderly and the provisions of Title VI of the Older Americans Act, which authorizes for services to the Indian elderly;
- requesting continued funding for Indian food and nutrition programs and the Women, Infants, and Children's (WIC) program on reservations;
- requesting increased support for improvement services for Indian children;
- opposing the establishment of nuclear waste disposal sites on Indian lands because of potential health dangers of such sites.

In addition to these resolutions presented at the national conference, the board adopted three other major resolutions at its meeting, including:

- support for the National Congress of American Indians (NCAI) strategy to reduce the problem of alcohol and drug abuse on Indian reservations. This strategy includes: a request for Congress to establish a long range commitment to reducing the problem of Indian alcoholism; providing for congressional oversight hearings to monitor the progress of Indian alcoholism programs; and recommending the establishment of a federal inter-agency task force to coordinate resources needed to address the problem of Indian alcoholism;
- supporting the continuation of the Public Health Service Commission Corps, which accounts for the majority of IHS physicians;
- recommending increased federal efforts in the early identification and treatment of cancer in Indian populations, including: increased research into the causes for high rates of cancer and leukemia in Indian populations, with special emphasis on environmentally induced causes such as uranium mining; implementation of a voluntary screening program that would provide for an early detection of cancer among Indian patients; and forming a Native American Cancer Society to address the special needs for cancer treatment among Indian populations.

Copies of each of these resolutions can be obtained from the NIHB central office. The board's next quarterly meeting is scheduled for October 26-30, and will be hosted by the United South and Eastern tribes.
Navajo Youth Take Part in Alcohol Training Project

SALT LAKE CITY, UTAH — A project to alert Navajo Indian youth to the dangers of misusing alcohol, drugs and tobacco and teach them other ways to handle stress was started here July 13 at the University of Utah College of Health.

The Navajo Youth Risk Reduction Project is part of a $350,000 grant awarded to Utah health officials by the National Center for Disease Control in Atlanta, Ga. It is an outgrowth of a University study several years ago of the health problems of Native Americans and other special populations, including the elderly, indigent and handicapped.

Twenty-five Navajo 10th and 11th graders will be trained for two weeks to work as counselors for fifth graders who live on the sprawling reservation, which covers parts of southern Utah and northern Arizona.

Fifth graders were selected as the target group because health planners believe children at that age are usually free of strong biases and can be very successful at assimilating knowledge. A secondary goal is to interest young Navajos in careers in the health professions.

Project directors include David Dennison of the Utah Navajo Development Council; Dr. Cathy Summerhayes, director of the State Health Department’s Bureau of Health Promotion and Risk Reduction and adjunct professor of health; and Dr. Patricia Reagan, assistant professor of health.

Dennison says Navajo youngsters frequently turn to alcohol and drugs because they lack a positive self-image, partly because they are often confused over their true cultural identity.

“The pressures of being required to change from their native culture to that of mainstream America’s are unsettling and often too difficult for many of them to handle,” says Dennison, who is part Navajo and part Mohawk.

Studies show alcoholism to be a serious problem among Navajo men, whose death rate from cirrhosis of the liver for those in the 15-34 age group is 200 times greater than it is for the U.S. population as a whole. In addition, 6.9 times as many Navajo men die in automobile accidents, where alcohol is a significant contributing factor.

One of the highlights of the week-long training session will be Dennison’s lecture on the role of the Navajo medicine man in modern day health care. He will discuss ideas for integrating Navajo medical practices with those of Western societies.

Because medicine men are very perceptive about the psychosomatic basis of many illnesses, their ceremonies are frequently geared toward healing by giving a patient the assurance to relax.

Once the alcohol and drug education curriculum for the Navajo project has been completed, the material is expected to be used regularly in schools in San Juan County as well as those which the Bureau of Indian Affairs operates on the reservation.

Summerhayes says the curriculum, including instruction on the effects of alcohol and drugs on the human body, will be a modification of the “Here’s Looking at You” alcohol education program currently taught in the Seattle, Wash., public schools.

After the Navajo teenagers complete their training, they will assist fifth grade teachers in presenting the alcohol and drug abuse material on a regular basis, says Summerhayes.

IDDA Expands EMS Training Program

PHOENIX, ARIZ. — The Indian Development District of Arizona (IDDA) recently announced the expansion of the Emergency Medical Services Division to offer training in all areas of emergency services on a national basis.

Executive Director Grace McCullah also announced the appointment of Stephen Stuart Carter as Director of the new Emergency Services Division. Carter joins the IDDA staff from his position as Coordinator for the Emergency Care Division of the University of Maryland, Fire and Rescue Institute. He has more than 12 years experience in emergency service training and operations.

IDDA has developed a nationwide team of adjunct consultants and trainers who are recognized experts in various emergency service disciplines. This expertise will be available to Indian communities across the nation as well as to the private industry sector. The IDDA emergency services team will offer a wide range of basic and specialized training, as well as consulting services.

EMS Management and Administration Seminars are tentatively scheduled for the months of October, November and December. The October program will be in the Phoenix area; the sites for the additional programs will be released at a later date. Special emphasis is being placed in the preparation of management and administrative programs for emergency services personnel.

IDDA will continue to make available the basic 40-hour First Responder and 81-hour EMT/A programs while moving into advanced life-support field training. Special rescue courses such as cave-in, mountain, and white-water rescue are available, in addition to basic rescue courses.

Basic fire fighting programs are under development and will be available in the fall. Special programs in hazardous materials incidents and disaster preparedness are currently offered by the IDDA staff.

Continuing education programs for emergency services personnel are available and may be tailored to local needs. Basic refresher programs are also offered in the First Responder and EMT/A curriculums.

Continued on Page 15
Navajo Youth...

Continued from Page 14

She says these specially-training 10th and 11th graders will serve as "responsible Fonzie's," a reference to the popular character on the television series, "Happy Days."

"In developing his character on television, 'The Fonz' has come out against the irresponsible use of drugs and alcohol," says Summerhays. "So our intention is for Navajo students that we train to fill similar roles in working with younger children on the reservation."

In addition, the Navajo concept of holistic health, of being in harmony with self, will be woven into the curriculum, says Reagan. "We want to borrow from the Navajo culture and traditions," she says. The children will also be taught how to identify credible sources of information and resist persuasion in a segment of the program that could be described as "social inoculation."

IDDA Expands...

Continued from Page 14

The resource personnel of the Emergency Services Division are prepared and able to design special programs that meet local training needs. Staff trainers and consultants are experienced in the design, implementation, operation and evaluation of emergency service systems as well as in the training functions.

The Division is also planning an active contract training program for private industry and governmental agencies. Personnel familiar with the Occupational Safety and Health Administration requirements are prepared to assist industry with consulting and training problems.

Information concerning the consulting and training services of the Indian Development District of Arizona are available by writing: The Emergency Services Division; Indian Development District of Arizona; Suite A-108, Phoenix, Ariz. 85015; or by calling (602) 248-0164.

Navajo Man Works to Improve Conditions for Handicapped

by Duane A Boyal
staff writer, "Navajo Times"

WINDOW ROCK, ARIZ — In 1967, a coal-mining accident left Joe Lee Yazzie confined to a wheelchair. Instead of giving in to depression, Yazzie has become an advocate for the estimated 13,000 handicapped citizens of the Navajo Nation.

Despite the enactment of laws for the needs and rights of the handicapped, Yazzie notes that there is still a long way to go to overcome barriers that block employment opportunities, participation in community affairs and other activities for handicapped persons. Attitudes toward the handicapped and architectural barriers still exist throughout the Navajo reservation.

Before his injury, Yazzie had friends and was involved in politics, but afterwards, he rejected counselors and fell into a depression.

"I put myself in a shell," he said. "Then my son, four years old at that time, said to me, 'I thought you were going to be a teacher, and show them how to be a man.'"

Yazzie bought a car, learned to drive it with hand controls and entered a school of engineering and drafting in Denver.

He finished school, qualified for a job at the tribe's Land Administration office. This was the beginning of the personal experience that led to his fight for the rights of the handicapped — there were steps leading into his new office, making it impossible to enter.

A ramp was built to accommodate wheelchairs. "I guess I left my landmark, it is still there," he said.

Despite his qualifications, he was given menial work, something all handicapped must deal with. This treatment of the handicapped is attributed to attitudes of people.

"People are unfamiliar as to how to deal with a handicapped person," notes Yazzie.

Yazzie left that job and became a vocational rehabilitation counselor in New Mexico. He helped a client through the typical problems of the handicapped. "It took going to a CAC worker and three chapter meetings to get him hired," remembers Yazzie. "The chapter people kept saying to him, 'stay home, we don't want you to get hurt.'"

Yazzie is now a compliance officer coordinating his efforts with the Navajo Vocational Rehabilitation Program and the newly created Navajo Nation Council on the Handicapped.

His concerns are to see that the laws guaranteeing the rights of the handicapped are implemented. "Some people respond," he said, "and some I have to return to twice for requests."

Yazzie is often frustrated in his attempts. "People say 'I know' (about the laws) but when you follow up a year later, nothing has been done," he said.

The laws are the Architectural Barriers Act of 1969 and the Rehabilitation Act of 1973. Sections of those laws can result in federally funded programs being denied funding if mandates are not followed.

The first law attempts to guarantee that the handicapped will have equal opportunity to employment and training, and the second mandates that public buildings be constructed as to be accessible to the physically handicapped.

Future projects for Yazzie include a parking lot at the tribal fairgrounds for handicapped persons. Presently, people in wheelchairs must wheel the half-mile distance from the front gates.

Also, Yazzie says the tribal council chambers are currently inaccessible to handicapped persons unless they are helped by other people.

Yazzie, with a son who is active in sports for the Window Rock Scouts, says he had to keep going back to former superintendent Dr. Ken Ross for two years in order to get a ramp for wheelchairs installed at the fieldhouse and the football field.

"All I'm asking," concluded Yazzie, "is that the public work toward the elimination of architectural barriers."
Urban, CHR Programs Slashed in Senate Markup

WASHINGTON, D.C. — Urban Indian health projects and the Community Health Representative (CHR) program were among the areas recommended for reduced funding in the second round of congressional markups on the Indian Health Service (IHS) budget for FY 1982.

The Senate Committee on Appropriations unexpectedly recommended no funding for urban Indian health projects, compared to the Administration's request of $4.5 million for the projects. In June, the House approved a funding level of $9.79 million.

The CHR program was also reduced $4.5 million from the level requested by both the Administration and the House. "Increased direct services provided through new and replacement hospitals and clinics and associated staffing increases should reduce the need for CHR's," according to the committee report.

Other health service areas trimmed by the Senate include Indian health manpower (decrease of $3.3 million from House recommendation); mental health services (decrease of $1.8 million from House recommendation); and the Equity Health Care Fund (decrease of $2 million from House recommendation).

In the area of IHS facility construction, the Senate Committee recommended a $2 million increase for planning and design funds for hospitals at Sacaton, Ariz., and Rosebud, S.D.; and added $350,000 to plan for health personnel quarters at the hospital in Chinle, Ariz. The Senate committee voted to decrease the House allowance for sanitation facilities by $2.5 million.

In total, the Senate committee recommended $626.8 million for health services, compared to the Administration's $626.8 million request and the House recommendation of $629.4 million. For facilities construction, the Senate committee approved an appropriation of $46.6 million, compared to $46.7 for the House and only $8.1 million requested by the Administration.

The committee's bill must be approved by the full Senate before being sent to a House-Senate conference committee, where differences between the two versions must be resolved. The funding levels identified in the appropriations legislation, if approved, would begin October 1, 1981 and end September 30, 1982.

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Address Correction Requested