Indian Health Programs Face $27.5 Million Shortfall in '82

WASHINGTON, D.C.—With the current fiscal year more than three-quarters complete, the uncertainty over several key items in the Indian Health Service (IHS) budget continues to disrupt a number of federal, tribal and urban Indian health programs.

Still unresolved in the FY 1982 budget are matters related to the payment of some $18.2 million in IHS salary increases; the planning and construction of Indian hospitals and health clinics; a potential $9.3 million deficit in hospital and health services; and a Reduction-In-Force (RIF) proposal to cutback IHS staff.

The issue of pay raises for IHS employees recently attracted national attention when syndicated columnist Jack Anderson reported the Administration’s plan to partially finance the increases with funds presently earmarked for planning and construction of five Indian health facilities (see pg. 4 for Anderson’s article).

As proposed by the Department of Health and Human Services (DHHS), the plan calls for the transfer of $11.1 million from facilities construction as well as $7.1 million in a supplemental appropriations to cover IHS pay increases. Congress authorized the increases as part of the FY 1982 Pay Act but thus far has not provided funds for them.

Under the proposal, which requires congressional approval, funding would be reprogrammed from the construction of clinics at Anadarko, Okla.; Tsaile, Ariz., and Huerfano, N.M.; and for the planning of hospitals at Sacaton, Ariz., and Rosebud, S.D. Construction and planning activities would continue for hospitals at Tahlequah, Okla.; Chinle, Ariz.; Browning, Mont.; Crownpoint, N.M.; and Kanakanak, Alaska.

A second reprogramming request, submitted to Congress in April, seeks to transfer $9.3 million from various health service activities into the budget for hospital and clinical services. IHS officials explain that the move is necessary to maintain existing patient care services and prevent the closing of health facilities.

The $9.3 million request, which requires approval from congressional committees, would rechannel monies from the following categories: maintenance and repair ($4 million); contract health care ($2.1 million); equity health care fund ($2 million); and savings from delays in filling certain positions ($1.2 million).

A number of tribes and Indian organizations, including the National Indian Health Board, have strongly opposed both reprogramming requests, urging Congress to instead appropriate a supplemental increase to cover the entire $27.5 million shortfall in this year’s IHS budget. Congressional committees are expected to address this matter sometime in July.

In a separate move aimed at saving money and providing for additional administrative flexibility, IHS has

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FUNDING LIMITATIONS have restricted the purchase of IHS medical equipment and limited repairs on Indian health facilities. Marianne Heslop, a nurse at the Shiprock Hospital on the Navajo Reservation, displays a home-made board used as a back rest for patients. A fundraising drive has been initiated to generate monies for much-needed repairs at the hospital.

Indian Health...

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requested authority to carry out a Reduction In Force (RIF) that could result in the transfer, demotion, or dismissal of an undetermined number of IHS employees.

However, according to one high-level IHS official, the RIF request was returned to IHS for alternate recommendations. If eventually approved only a few IHS employees will actually lose their jobs, while others will be transferred and placed in different positions, the official predicted. A final decision on the RIF request is expected within several weeks, he said.

Another personnel-related issue that potentially affects IHS patient care concerns an Office of Management and Budget (OMB) directive to limit entry of certain health professionals into the Public Health Service Commissioned Corps. IHS relies heavily on Commissioned Corps health professionals, particularly in serving isolated reservation locations. More than 75 percent of IHS health professionals are Commissioned Corps personnel.

The directive from OMB, which over the years has made numerous unsuccessful attempts to abolish the Corps, would restrict the recruitment of Commissioned Corps professionals to physicians and dentists. IHS officials claim this limitation will seriously hamper the hiring of pharmacists, optometrists, sanitarians, and other health personnel, create staffing shortages, and lead to the "disintegration and closure of many IHS facilities."

The OMB proposal has been strongly opposed by tribes, health organizations, and members of Congress. At a recent hearing of the House Subcommittee on Health and the Environment, Representative Henry Waxman (D-Calif.) expressed dismay that Administration policy regarding the Corps has been made by OMB budget officers and not by those responsible for the program.

In an apparent effort to halt such OMB attempts, Congress agreed to a provision in the Urgent Supplemental Appropriations bill (H.R. 5922) to prohibit OMB from "phasing down" the Corps. However, with President Reagan likely to veto H.R. 5922, the status of this OMB directive is uncertain.

A final item of the tumultuous FY 1982 budget year concerns the IHS evaluations of Community Health Representative (CHR) programs, alcoholism projects, and urban Indian health centers. According to a recent IHS memorandum, all contracts for these three activities are to be funded only through August 31. After "program decisions have been made," the directive states, funding will be provided "on a case by case basis" to either close down the projects in September or provide for ongoing funding for FY 1983. Decisions based on the evaluations are expected in the coming weeks.

Given the troubles surrounding the current fiscal year budget, federal and tribal health officials are nervously awaiting the outcome of congressional action on next year's budget.

Earlier this year the Administration announced its FY 1983 recommendations for a $613 million IHS budget that calls for the elimination of CHR and urban programs, plus a steep cut in IHS health scholarship funds. The Reagan budget also requests no funding for the construction of Indian hospitals, clinics, and sanitation facilities.

Whether Congress chooses to accept these cuts remains to be seen. But indications are that even if funds are restored Indian health programs face serious fiscal constraints in the future. In its report on FY 1983 authorization levels, the Senate Select Committee on Indian Affairs recommends continued funding for CHR and urban programs. However, the Committee also recommends that funding for these and other IHS activities (program management, tribal management, Indian health manpower, and preventive health) be held to FY 1983 levels through the following four fiscal years, with only a slight increase provided each year for clinical services.

As indicated by IHS Director Dr. Everett Rhoades before a congressional committee this spring, IHS and tribes may be required to examine the wider issues of eligibility and scope of service in order to endure future budgetary constraints. For the immediate future, the status of Indian health programs rests with the congressional appropriations committees that will markup the IHS budget for 1983. These markups are scheduled to be completed by early September.
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 relate 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.

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LAPWAI, IDAHO—The Northern Idaho Indian Health Board (NIHB) has received a $35,000 grant from the Joseph P. Kennedy Foundation to provide educational and daycare assistance to pregnant and parenting adolescents of the Nez Perce, Coeur d'Alene and Kootenai Tribes. The services will allow daycare assistance and counseling to those teenagers who want to complete their education or pursue a vocation. According to NIHB Director Jo Ann Kaufmann, “the goal of this effort is to improve teen parent survival, promote positive parenting and rebuild emotional well-being and stability back into the lives of teen parents.”

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PHOENIX, ARIZ.—The Phoenix Service Unit Indian Health Advisory Board has established a special eyeglass program that offers reduced prices on prescription glasses, sunglasses and frames. The program's discount prices are approximately 30 percent less than the average retail price. For further information contact: the Phoenix Service Unit Health Advisory Board; Phoenix Indian Medical Center; 4201 N. 16th St., Suite 260; Phoenix, Ariz. 85016.

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DENVER, COLO.—The National Indian Health Board (NIHB) will conduct its next meeting here at the Denver Regency Hotel July 27-28. Tentative agenda items include a working session with Indian Health Service (IHS) Area Directors and a presentation by IHS Director Dr. Everett Rhoades. For additional information about the meeting, contact Linda Standing, NIHB Board Coordinator, at the NIHB central office.

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OKMULGEE, OKLA.—“Our National Resources for Sale — Our Health at Issue” is the theme of the 11th Annual Meeting of the Association of American Indian Physicians (AAIIP) to be held at the Creek Nation Tribal Complex here July 22-23. A number of distinguished researchers are scheduled to deliver papers on environmental health hazards relating to American Indians and their reservation lands. Topics to be discussed include public health risks associated with uranium mining and milling; pediatric perspectives of environmental hazards; and birth effects among Indians in the Four Corners Area. Registration fee for the meeting is $30. For further information contact John Belindo, Executive Director, AAIIP; 6805 S. Western, Suite 504; Oklahoma City, Okla. 73139. Phone (405) 631-0447.

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ROCKVILLE, MD.—The Indian Health Service has developed guidelines for establishing tentative funding levels for FY 1983 tribal contracts under P.L. 93-638 (the Indian Self Determination and Education Assistance Act). The guidelines, contained in Indian Self Determination Memorandum No. 82-3, “provide instructions for negotiating P.L. 93-638 contracts for 1983 prior to an enactment of an appropriation for the Indian Health Service in 1983.” The memorandum is expected to be released from the NIHB Public Information Office.

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HOGANSBURG, N.Y.—The St. Regis Mohawk Tribe is seeking applicants for the position of health director. The tribal health services program includes a comprehensive medical clinic and extensive preventive services. For further information contact: Ester Loran; St. Regis Mohawk Health Services; Community Building; Hogansburg, N.Y. 13655. Phone (518) 358-2272.

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PHOENIX, ARIZ.—Issues related to the health and well-being of Indian youth will be among the workshop topics at the Fourth National Indian Child Conference here September 12-16. The conference is sponsored by Save the Children, one of the largest non-governmental assistance organizations in the country. Registration materials can be obtained by contacting: Dallas Johnson, Conference Director; National Indian Child Conference; 5101 Copper, N.E., Suite 1; Albuquerque, N.M. 87108. Phone (505) 265-8705.

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WASHINGTON, D.C.—T. J. Harwood, Director of the Albuquerque Area Indian Health Service, received the Administrator’s Award for Excellence here June 25. The award, which is the highest bestowed by the Health Services Administration, was presented to Harwood for “outstanding leadership in improving and strengthening the program management of the Albuquerque Area Indian Health Service health care delivery system and for his total and professional commitment and dedication to American Indians.” As Director of the Albuquerque Area IHS, Harwood oversees a health care system that provides services to more than 47,000 Indians residing on 26 reservations in New Mexico and southern Colorado. Harwood, an enrolled member of the Blackfeet tribe in Montana, is a 25-year career employee with IHS and has served as Albuquerque Area Director since April, 1977.

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**Jack Anderson**

**Hospital Funds Go To Pay Bureaucrats**

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Bureaucrats in Washington are often suspected of putting their own comfort above the welfare of those who depend on the government for basic survival needs. But it’s a rare occasion when one of them will admit it.

I’m dismayed to report that officials at the Office of Management and Budget and the Health and Human Services Department have decided to use hospital construction funds to make sure that employees of the Indian Health Service get their promised salary increases.

“It’s a matter of priorities, and salaries are a higher priority than the construction of hospitals,” OMB budget examiner Barbara Kivimae told my reporter Esther Pessin.

Here’s the shocking situation:
The mandated pay raises for IHS bureaucrats will

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FORT COLLINS, COLO.—Five tribes have been selected to take part in a National Indian Health Board (NIHB) Science Center study to investigate how scientists conduct research in Indian communities. The study, called the “EVIST project” (Ethics and Values in Science and Technology), will attempt to “identify mechanisms which tribes will be able to use to improve relationships between Indian people and scientists,” according to Alan Ackerman, one of the principal investigators on the project. The EVIST study is funded through a $264,000 grant from the National Science Foundation. The five tribes selected to participate are: the Zuni Pueblo of New Mexico; the Rosebud Sioux Tribe of South Dakota; the Navajo Tribe; the Hopi Tribe; and the Sycuan Band of Mission Indians in California.

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WASHINGTON, D.C.—The American Public Health Association (APHA), the nation’s largest private health organization, has established an American Indian and Alaska Native caucus to address special health concerns of Indian populations. According to caucus president Margo Kerrigan, the 50,000 member APHA has the political influence and professional expertise necessary to adequately address Indian health concerns. Kerrigan stated that the caucus will work: to improve the quality and increase the number of professional research projects concerning the health care of Indian people; to affect a national policy towards an improved Indian health care system; to assist in the recruitment of health professionals for Indian health programs; and to further involve Indians in the planning and delivery of health care services. For additional information about the Caucus, contact: Margo D. Kerrigan, MPH; 2422 Arden Way, Suite A30; Sacramento, Calif. 95825.

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result in an $18.5 million deficit in the agency’s budget. Casting about for some way to plug the gap, OMB and HHS officials hit upon $11.6 million earmarked for construction of medical facilities on five Indian reservations in the West.

Three clinics in Oklahoma and New Mexico will be axed from the IHS budget if the attempt to rechannel the money into salary increases is successful. In addition, master plans for desperately needed hospitals on the Gila River Reservation in Arizona and the Rosebud Reservation in South Dakota will never get off the drawing board.

The 9,500 Pima and Maricopa Indians at Gila River suffer the highest incidence of diabetes in the world. Kidney disease, directly linked to diabetes, is rampant on the reservation.

Sacaton Hospital, the 40-year-old government facility on the reservation, doesn’t begin to meet the Indians’ needs. “It’s no more than a first-aid station,” said Susan Harjo, legislative liaison for the Native American Rights Fund.

The hospital is operating at one-third capacity. There are only six doctors to handle 30,000 or more outpatient visits a year, plus all the inpatient care. There are no facilities at Sacaton to treat diabetes. There isn’t even a dialysis machine available for patients suffering from the kidney disease that often results from inadequately treated diabetes.

“We could probably prevent diabetes if we had a good hospital on the reservation,” said an IHS unit director. But diabetic Indians often go blind or require amputation because of the disease.

The hospital is “both physically and operationally obsolete,” according to an IHS report. The obstetrics ward was recently closed, and for major medical care, the Indians must go 40 miles to the IHS hospital in Phoenix.

At Rosebud, in South Dakota, 8,000 Sioux live in abject poverty; unemployment stands at 83 percent. The Indians have been waiting 10 years for a new hospital to replace the existing 70-year-old facility, part of which was condemned in 1978 as “unsafe and structurally unsound.”

The Rosebud Hospital meets only 30 to 40 percent of the Indians’ needs. Seriously ill patients are flown out to Rapid City, Denver or Minneapolis, and when winter storms prevent flights out, “we treat them here — and pray a lot,” as one official put it.

The Indians’ need is clearly desperate. Yet money that would help them is going instead for bureaucrats’ pay raises, if the fatcats in Washington have their way. President Reagan takes unremitting heat for the sometimes dire effects of his administration’s budget cuts. As the IHS case shows, though, it’s often some faceless bureaucrats who decide where to make the cuts.

Footnote: Congressional approval is needed before the hospital construction funds can be used for salaries. OMB and HHS officials said they fully expect the lawmakers to sanction the move.
Since 1974, researchers at the Western Behavior Studies at Colorado State University (CSU) have conducted extensive studies of drug use among American Indian youth. Their findings are discouraging: the incidence of drug abuse among Indian young people is high on many reservations, and the problem will likely become worse in coming years.

Last year, we published an article detailing the level of drug use in Indian communities. But statistics and percentages are too impersonal to show what really happens to Indian children that frequently use drugs. The following article describes the drug problems of an 11-year-old Indian girl. Her name, Loretta, is fictitious, but her life, experiences, and difficulties with drugs are real.

The article, written by Dr. Fred Beauvais, Dr. E. R. Oetting, and Ruth Edwards of Colorado State University, is based on the authors' research in the area of drug abuse, and in particular on the responses they received from this young Indian girl. Comments on this article, or requests for additional information about drug abuse problems on reservations, may be sent to the authors at the Western Behavioral Studies; Department of Psychology; C78 Clark Building; Colorado State University; Fort Collins, Colorado 80523.

Loretta is 11 years old, which may seem very young for drug use but it is not at all uncommon. About three percent of Indian children her age use drugs as much as she does.

Loretta first tried drugs at age eight, in the second grade, when she used marijuana and inhalants to get high. She sniffed gasoline fumes almost once a week during that year. Since that time her use of drugs has increased. She now uses marijuana or sniffs inhalants, usually gasoline or fingernail polish, nearly every day. She does not just use drugs socially, as something to do with friends, but she uses them when she is alone.

Alcohol is the drug most commonly used by young children. Loretta drinks at least some wine or beer several times a week; sometimes until she "feels it a lot." She has never had so much that she passed out or became sick from drinking, but she has been "drunk one or two times" in the past recent months.

Boredom, Poor Self-Image, Lead Young Indian Girl to Drugs

Loretta has also taken pills to get high on several occasions. When asked what kind of pills, Loretta indicated "speed," although neither we nor Loretta know what she actually took. Pills sold as "speed" can be as innocent as caffeine or as dangerous as PCP.

Where does Loretta get these drugs? She is only 11 years old and has very little money. According to her, the main source for alcohol and something to sniff is "an aunt in the 7th grade" but she also gets them from "two other people," and gets her marijuana from a 21-year-old aunt and uncle. We have found that Indian children frequently get their drugs from older children in the family, often brothers and sisters. Loretta does not have any older brothers or sisters, but older relatives fill the same role for her.

Loretta appears to be like other young children that seem to know about the dangers of drugs but use them anyway. When asked whether it is bad to use marijuana, to drink, or to sniff, Loretta answers "a lot." But knowing that drug use is bad does not stop her from using them.

Children use drugs for many different reasons, and this is evident with Loretta. She is depressed and has a low level of self esteem. She is lonesome, she does not like herself, and does not feel that she is good looking. She says that using drugs and drinking makes her feel less sad, helps her get rid of unhappy feelings and, at least briefly, changes the way she feels.

Loretta's reasons for drug use also include boredom. There are not many activities for children in her community, at least not ones that appeal to her. She says Continued on Pg. 6
that she drinks and sniffs because there is "nothing else to do around here" and "because I'm bored."

Other reasons are social. Despite her lack of self esteem, she seems to get along reasonably well with other children and she has friends. But these friends form part of the social environment that relates to her drug use. Among her reasons for using drugs are statements such as "to be with other kids" and "because other kids do it." For children, peers are a very important social group and in Loretta's case the peer pressure is toward and not away from drugs.

**Reasons for Drug Use**

What caused the original personal problems that made drugs an attractive alternative to Loretta? The roots of these problems can be found in three areas: in the sociocultural context, in the family, and in the schools.

Loretta is Indian. Despite the many strengths in the Indian culture and life, there are negative pressures that affect her. Unemployment is high in Loretta's tribe, and she knows what it is to be poor. Her reservation is isolated and life can become monotonous and boring. When her family can occasionally drive to an off-reservation town, they must sometimes confront open prejudice.

A strong family can help children by communicating negative attitudes toward drugs, by helping them build pride and by making them feel worthwhile and loved. Loretta comes from a broken home, which is true for many Indian children. Sometimes the remaining extended family is strong enough to support the child, but apparently not in Loretta's case. She says that her family does not care much about her or about what she does and that they only care "some" about her sniffing and drinking. She does say that they are very negative about marijuana, but even these messages are not clear. The older people may care, but she is actually getting her drugs from younger members of her family.

The feeling that she is not really cared for or worthwhile may have been made worse by school. Heavy drug users frequently have a problem with school adjustment, and Loretta is not an exception. While she reports doing "OK" on school grades and that her teachers like her "a lot," she does not like school, feels it is not fun, does not picture herself as a good student.

What does the future hold for Loretta? In her own view, not much. On a list of ten possible descriptions of "What is your future going to be like?", she picked only two very negative statements: "I will be sick a lot" and "Bad things will happen to me." This bleak outlook has been found in many other young Indian children who use inhalants heavily, and may be another reason that Loretta uses drugs so much. She knows that they are bad for her, but if there is no hope for the future then why not take some form of immediate relief or pleasure?

Drug use may make Loretta's predictions about her future come true. There are both physiological and social consequences from taking drugs. For example, if she is sniffing leaded gas she may even now be suffering from lead poisoning, damaging her body and mind. The death rate from accidents and suicides is high among Indian youth, and alcohol and drugs can increase this danger. With this heavy an involvement in drugs and with friends who are also involved, she is likely to move on to other drugs as she gets older, risking addiction, further damage to her system, or possible overdose from a combination of drugs.

**What Can Be Done?**

This description of Loretta is not a fairy tale — she is a real, living person who is very troubled. The picture is indeed a sad one, but the intent here is not just to evoke emotion. By understanding the factors which have influenced Loretta and many others like her, it may be possible to help other Indian children from encountering similar problems.

For example, if Loretta's family had been more stable, or if she had experienced a more secure and loving home life, she may have steered away from drug use. Unfortunately, Loretta's home life is not unique.

Many reservation families feel very discouraged and have lost hope that their problems will ever change. The lack of jobs, adult alcoholism, chronic health problems and rapidly changing social and cultural values create a malaise which often leaves Indian people feeling powerless to control their lives or the lives of their children. Often this problem can be countered by the development of parent groups who come together to address common problems. These groups can be a source of strength for individual families and provide a forum where group action can be initiated. Such concerted effort by parents can give a loud and clear message to young people that drugs and alcohol are dangerous and contrary to the Indian way of life.

Loretta also indicated that one reason for her using drugs and alcohol was boredom. Research has shown that there is less drug use in Indian communities where there are many activities for young people. Adequate recreational facilities, sports programs, after-school activities, and summer camps could provide ways of directing youngsters away from drug use.

In addition, Loretta has a very high interest in Native American culture. She says she would like to speak an Indian language and take part in Indian activities and events. Like many Indian young people Loretta is expressing a need for a solid cultural base, a safe and secure place from which she can develop her own values in life.

Much has been written about the Indian child "caught between cultures." In recognition of this dilemma, many Indian communities have developed programs intended to restore knowledge of traditional Indian values and instill pride in Indian heritage. While these programs are laudable they may supply only a partial answer.
NIHB Offers Group Insurance Plan

DENVER, COLO.—With hospital and other health care costs outpacing inflation, most commercial insurance companies have substantially raised their rates over the past two years.

In an effort to offer tribes and Indian organizations an alternative to these increased rates, the National Indian Health Board (NIHB) has established a national program that offers premium health care benefits at low rates. Employees of tribes and Indian organizations are eligible for the coverage.

NIHB will operate the program in cooperation with the American Indian National Bank in Washington, D.C. The program is designed to provide employees of participating tribes coverage against major medical problems, hospitalization, accidents, maternity expenses, and most other costs associated with health care.

While the program has two basic plans for coverage (see description below), it is flexible enough to provide other kinds of benefits as well as life insurance. Cost of the program is considerably lower than most commercial plans, according to NIHB administrators.

For additional information about the NIHB health insurance, please contact: National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.

PLAN A

HOSPITAL — NO DEDUCTIBLE
The Plan pays 100% of the first $4,000.00 and 80% of the next $2,500.00; then 100% thereafter.

(Room and Board not to exceed semi-private charge).

OTHER MEDICAL —
$100.00 Deductible per year. Once the deductible has been satisfied, the Plan pays 80% of the next $2,500.00 (Room and Board not to exceed semi-private charge) and then 100% thereafter.

SUPPLEMENTARY ACCIDENT —
The Plan pays 100% for treatment of accidents up to $300.00.

MATERNITY —
Treated as any other illness.

POLICY LIMIT —
$250,000.00

Health News...

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WASHINGTON, D.C.—The Bureau of Indian Affairs announced a major administrative reorganization to consolidate the 12 existing BIA area offices into five regional service centers located at Albuquerque, N.M.; Anadarko, Okla.; Aberdeen, S.D.; Phoenix, Ariz.; and Portland, Ore. According to Assistant Secretary of Indian Affairs Ken Smith, the BIA reorganization will create a $16 million annual savings while improving “the efficiency of implementing Bureau programs and services.” The change in the BIA administration structure does not affect the present operation of 12 Indian Health Service area offices.

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OKLAHOMA CITY, OKLA.—The Association of American Indian Physicians (AAIP) recently named John Belindo as its new executive director. Belindo, a Kiowa-Navajo, has long been involved with Indian health issues and national Indian affairs. He replaces long-time AAIP director Bill Wilson, who has accepted a position with the Indian Health Service as special assistant to the director.

PLAN B

HOSPITAL and OTHER MEDICAL —
$100.00 Annual Deductible.
Deductible waived for accident claims.

Once the deductible has been satisfied, the Plan pays 80% of the next $2,500.00 (Room and Board not to exceed semi-private charge).

Any additional covered expenses are paid at 100% (for the remainder of the calendar year).

MATERNITY —
Treated as any other illness.

POLICY LIMIT —
$250,000.00

NATIONAL INDIAN HEALTH BOARD
1602 South Parker Road, Suite 200
Denver, Colorado 80231

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91 Persons Honored for Efforts to Improve Indian Health Care

TUCSON, ARIZ. — Two Navajo Indians and an Illinois congressman were among the 91 individuals recognized for their dedication, hard work, and contributions toward improving the health care of Indian people during an awards presentation here April 22 at the Fifth National Indian/Alaska Native Health Conference.

Presented by the National Indian Health Board (NIHB), the awards represent "our attempt to say 'thank you' to these people for their efforts in bringing about better health care for Indians and Alaska Natives," says Jake Whitecrow, NIHB Executive Director.

The awards, which are divided into three categories, were presented to individuals and organizations who over the years have contributed significantly to: furthering the health care benefits and services to American Indians and Alaska Natives as provided under the treaty rights and/or laws of the United States; giving the public a better understanding of matters and problems of health affecting American Indians and Alaska Natives; enhancing and promoting the education and understanding of members of American Indian tribes and Alaska Native villages in health and welfare matters; seeking an equitable adjustment of public health services among participating Indian tribes and Alaska Native villages; and promoting the health and common welfare of American Indian and Alaska Native people.

In the first category of awards, which requires unanimous approval from the Board of Directors, specially-designed NIHB plaques were given to Dr. Annie Wauneka and Elwood Saganey of the Navajo Nation, and Congressman Sidney Yates (D-Ill.).

Sometimes referred to as "the First Lady of Indian health," Dr. Wauneka has devoted most of her adult life to improving the health conditions on the Navajo Reservation, where her work has been instrumental in reducing the levels of tuberculosis, diarrhea, and other major illnesses. Dr. Wauneka, who in 1951 became the first woman ever elected to the Navajo Tribal Council, has served as the tribe's health envoy and has supported enactment of health legislation and programs on a national basis.

Saganey has served as the Navajo representative to the National Indian Health Board since 1972, and is past chairman of the Board. He has been active in a number of health-related activities with his tribe, particularly in the area of treatment and prevention of alcoholism. Saganey has served on the Navajo Tribal Council since 1971, and is chairman of the council's Health, Alcoholism, and Welfare Committee.

Congressman Yates, a 32-year veteran of the U.S. House of Representatives, is a longtime supporter of Indian health programs. "He fully understands the federal-Indian relationship, and he has attempted to insure that the United States fulfills its obligation to American Indians," says NIHB Director Whitecrow, who


In the second category of awards, amber-colored NIHB medallions went to 13 individuals whose contributions have helped advance the health status of Indian people. These awards were given to: John Emelio, IHS program director for emergency medical services, who has coordinated efforts to improve ambulance and emergency services on Indian reservations; James Abourezk, former U.S. Senator who helped secure passage of the Indian Self-Determination and Education Assistance Act (P.L. 93-638); Senator John Melcher (D-Mont.) who strongly supported amendments to continue programs authorized by the Indian Health Care Improvement Act (P.L. 94-437); Senator William Cohen (R-Maine), present chairman of the Senate Select Committee on Indian Affairs; John Porvaznik, M.D., Acting Director of the Navajo Area IHS, who was named the IHS Outstanding Clinician by the National Council of Clinical Directors; Wendell Chino, President of the Mescalero Apache Tribe in New Mexico and former President of the National Tribal Chairmen's Association; Lionel Demontigney, M.D., chief of IHS community development; Dr. Joseph Exendine, IHS Deputy Director; Bryce Poolah, M.D., of the Association of American Indian Physicians; Daniel Press, attorney and former NIHB general counsel; Lois Steele, M.D., director of the Indians Into Medicine (INMED) program in Grand Forks, N.D.; Mel Sampson, Yakima Tribal Councilman, Chairman of the Northwest Portland Area Indian Health Board, and NIHB's Portland area representative; and

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Agnes Nichols, member of the Alaska Native Health Board, who has worked for years to improve the system of health care for Alaska Natives.

In addition, 65 individuals and 7 organizations were recognized with NIH Certificates of Appreciation for their commitment and hard work in the Indian health care field. Some reasons cited by constituents and colleagues in their nominations include: "genuine and untiring compassion for their patients;" "outstanding leadership and consistent ability to solve problems;" "patience and calm administration in near-chaotic situations;" and "efforts to improve the overall quality of life for the Indian elderly."

Certificates of Appreciation were presented to: Dr. James Felson, Michael Lincoln, Dr. Ralph Dru, Dr. Marlene Echahawk, Walter Moffett, Bill Wilson, George Hawkins, Elaine Walbroek, Danny Whitekiller, Wes Halsey, Dr. Phillip May, Linda Bossert, Bob Hunter, John Belindo, Douglas Sakiestewa, Trudy Ware, Joe Beeler, Senator Dennis DeConcini, Senator Pete Domenici, Lionel John, Joel Frank, the Comanche Tribe, the Apache Tribe of Oklahoma, the Kiowa Tribe of Oklahoma, Florence Roy, Gladys Yackeyonney, the Seminole Tribe of Florida, the Penobscot Tribe, the Shoshone-Bannock Tribe, Pauline Whitebird, Congressman James R. Jones, Congressman Henry A. Waxman, Dr. John Todd, Emil Kosbruck and Jouce Smythe.

Certificates also went to: Nelson Gorman, Jr., Anita Valliere, Mountain Home Air Force Base, Dr. J. T. Garratt, Marvin H. Edeyold, Dr. Rupert O. Clark, Dr. John Hauxwell, Bruce C. Campbell, Alice M. Haggerty, Dr. Thomas K. Welfty, Dr. Paul Nutting, Dr. James Justice, Dr. Felix Hurtado, Dr. Elisa Hurtado, Lawrence Berg, Phyllis Eddy, Mary L. Raje, James Szooff, Dr. Jeffrey M. Newman, Dr. Gregory Schorr, Kent Ware, Arvinna Thayer, Lorna K. Call, Gloria McCullough, Ida Wolfe, Kenneth Andrews, Danny Sage, Violet Hillaire, Dorothea Johnson, Burton Platero, Marva Randolf, James

Lomakema, Sr., Daniel R. Norris, Jr., Anna Marie Williams, Ann Hemstreet, Duane Jeanette and Jerry Zitur. ■

Boredom ...

Continued from Pg. 6

Nearly all Indian young people will encounter a bicultural world in their future. It is probably impossible to return to a fully traditional way of life, but it is important to teach and maintain real Indian values. The future for most Indian youngsters will be strongly influenced by the non-Indian world—education, employment, lifestyle and health services are but a few of the elements. The central developmental task for these young people will be to reconcile these disparate worlds.

Research indicates that the better-adjusted Indian young people have been able to encounter both worlds with equal ease. They feel comfortable with their "Indianness" yet are unafraid to live competently in a non-Indian environment. These youngsters have a better self-concept, are more successful in school, have a brighter outlook on the future and have a much lower involvement with drugs and alcohol.

The implications of this finding are most important. Restoring Indian values and pride is necessary, yet teaching competence in the non-Indian world can be equally important. Loretta's plea for Indian identification should be met, and she needs to have solid Indian values and know what is right and wrong in the Indian way. But she also needs the skills that will allow her to negotiate "the other part" of her life.

One of the most immediate tasks for Loretta is to succeed in school. The reasons for this are both short-term and long-term. On most reservations, schools provide one of the few opportunities for a youngster to experience success. On a day-to-day basis school achievement can go a long way toward building a sense of self-worth. A youngster's outlook on the future is also shaped in part by their school experience. If they are able to do well in school they will see many opportunities for themselves down the road. Young people with a dim view of the future are much more likely to be involved with drugs and alcohol.

Certainly the schools are being asked to do a monumental job. Unless they are given a great deal of support and guidance from parents and other community members, they cannot provide the many functions required of them.

Finally, it must be recognized that efforts to reduce the incidence of drug abuse among Indian youth require a strong commitment and involvement by the adult population. Of particular importance here is the problem of alcoholism on the reservation. Where adult alcoholism is widespread it is difficult to muster the kind of support needed to reduce youth drug abuse. Adult alcoholism saps the strength of the community and conveys values and attitudes that probably encourage use of chemicals of any kind. Efforts to help young people will probably have to be made in conjunction with an attack on adult alcoholism. ■
On a deserted back-country road in rural Oklahoma a 55-year-old man was left bleeding and unconscious following a recent motorcycle accident. Linda Ford, a nurse who works with the Cherokee Nation Health Department, was able to stop the man's bleeding, stabilize his condition, and keep him alive until an ambulance arrived 45 minutes later.

Janet Bird, a 28-year-old specialist in maternal and child health care for the Winnebago Tribe in eastern Nebraska, coordinates efforts to immunize tribal children under the age of five against such illnesses as diphtheria, pertussis, tetanus, polio and rubella. Since 1979, when the tribe became involved in this effort, the child immunization rate on the Winnebago Reservation has improved from 40 percent to 99 percent. In addition to her MCH work with the tribe, Bird spends one day a week assisting staff at the reservation’s Indian Health Service clinic.

Mae Marshall, a nutritionist, travels hundreds of miles each week between isolated villages in the Copper River Region of eastern Alaska to provide nutrition education to school children, the elderly, and other village residents. The children know her as “the food lady.”

Diane Buckner, a registered Emergency Medical Technician, is the only local health provider for the residents of the Duckwater Shoshone Indian Reservation in central Nevada. She makes regular home visits to the elderly, families with small children, and those with special health problems. In emergency situations, she provides whatever treatment she can and, if necessary, contacts a physician by phone for instructions on further medical care. Once a week she takes several tribal residents to a small field health clinic in Elko, Nevada, more than 160 miles away.

In Indian and Alaska Native communities across the United States, hundreds of skilled professional and paraprofessional health workers provide similar services as part of a unique, community-oriented approach to health care. Known as Community Health Representatives, or CHR’s, these health personnel play an integral role in tribal health programs, especially through the provision of outreach and home health services. Thousands of Indian families residing in isolated reservations or rural locations, who have little or no access to health facilities, depend on CHR’s for a number of health services.

CHR’s Overcome Isolation Care to Reservation

Photo by Paul Natonabah, Navajo Times

PROVIDING HOME HEALTH visits and outreach services is one of the most important activities of the CHR program. On this visit, Navajo CHR Daisy Damon gives medication to Mrs. Glenhasbah Tsosie, who is 88 and partially blind and deaf.
Bad Roads to Provide Health Rural Indian Populations

Under contractual arrangements with the Indian Health Service (IHS), tribes employ CHR's in a variety of health-related professions, including registered nurses, emergency medical technicians, environmental health specialists, home health aides, dental assistants, maternal and child health specialists, general health outreach workers, and in other health specialties.

Working in tribal clinics, health outreach programs, and IHS hospitals, CHR's serve as the primary "link" between Indian communities and the medical system. Last year, approximately 2,100 CHR's provided more than 1.5 million services in Indian and Alaska Native communities nationwide.

Despite the overall effectiveness of CHR's, and the dependence of Indian populations on their health services, the program is in serious trouble and faces the prospect of elimination next year.

Since last October 1, the national CHR program has been reduced more than 20 percent because of IHS budget constraints, forcing most tribes to drastically curtail their CHR services. On the Fort Hall Reservation in Idaho, the Shoshone-Bannock tribal CHR program had to close down for an entire month because of lack of funds. Other tribes, such as the Papago in Arizona, have had to lay off a majority of their CHR personnel and reduce services as much as 40 percent.

Worse still is the outlook for the next fiscal year, which begins October 1. In its proposed budget for FY 1983, the Administration has recommended that the $29 million CHR program be phased out entirely.

A brief explanation of the proposed CHR cut was offered in a Department of Health and Human Services (DHHS) statement that was released with the IHS budget. According to the statement, the Administration recommends that existing IHS direct care services can be maintained "by refocusing resources from non-patient care activities. Decreases in non-patient care activities include $29 million due to the elimination of Federal funding of tribal staff who currently provide liaison and some health services for the IHS and Indian people under the Community Health Representative program."

"Non-patient Care Activities"

Tribal leaders across the country have bitterly condemned the Administration's recommended cut in the CHR program, arguing that it would devastate tribally-administered health programs and, rather than saving money, eventually increase the cost of certain health services.

Of particular concern to a number of tribes is the Administration's assertion that services provided by CHR's are "non-patient care activities." According to Dana Norris, Governor of the Gila River Indian Community in Arizona, "there must have been a lack of information concerning the use of CHR funds. Certainly the tribal programs at Gila River, which now constitute a vital part of the total IHS health care services available to my people, cannot be classified as providing "liaison and some health services for the IHS and Indian people."

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CHR's Overcome...

Continued from Pg. 11

Alva Schneider, former CHR director for the Cheyenne River Sioux Tribe in Eagle Butte, S.D., also criticized the Administration's interpretation of the CHR program. Health care services provided by CHR's on her reservation "are essential due to the isolation and long distances we need to travel to major hospitals," she says. "Most important of all," she continues, "is the fact the majority of our CHR's are state-certified Emergency Medical Technicians and are able to give life-saving services at the site of trauma situations. These trained CHR's have saved lives by being able to stabilize the patient until they can be taken to medical professionals."

CHR's have played an increasingly important role in the provision of ambulance and emergency medical services on reservations, according to John Emelio, IHS program director for EMS operations. On the 25,000 square mile Navajo Reservation, for example, the proposed CHR cut would virtually dismantle the tribe's extensive EMS program, leaving a geographic area the size of West Virginia without any ambulance services.

Elimination of the CHR program would also be a crippling setback to tribes that have strived for years to deliver their own health services under the concept of Indian self determination. "CHR's represent the only IHS-funded program almost exclusively under contract with Indian tribes," according to congressional testimony presented jointly by the National Indian Health Board, the National Tribal Chairmen's Association, and the National Congress of American Indians.

"The flexibility of this program has allowed tribes, for the first time, to determine types of services needed at the local level which bridge the gap between traditional delivery mechanisms. CHR's, on many reservations, are the only direct health care providers and assurers of health care continuity," states the national organizations' testimony.

Many tribal officials have also challenged the Administration's position that the CHR reduction will save money. According to the Northwest Portland Area Indian Health Board, which is comprised of 34 tribes in the states of Oregon, Washington and Idaho, "the Administration's attempt to save money in Fiscal Year 1983 by eliminating the CHR program is poor economy, because the (program) is extremely cost effective. The preventive, primary care, and rehabilitative services provided by CHR's help to keep Indian patients out of hospitals and nursing homes which... are prohibitively costly."

This kind of cost-effectiveness was documented in a study which found that health services provided by CHR's in Montana resulted in a decrease in patient hospitalization. Similarly, the Five Sandoval Indian Tribes in New Mexico contend that it would cost more than five times their current CHR budget to replace existing CHR services with other sources.

In addition to overwhelming criticism from tribes and Indian organizations, the Administration's proposed continued on Pg. 14
In letter to White House

Choctaw CHR Describes Typical Day's Work

Of the many responsibilities carried out by Community Health Representatives, none is more important than the health care they provide as field, or "outreach," workers. Each week CHR's visit hundreds of isolated Indian homes to give medication, check blood pressure, do routine health check-ups, and provide other health services as needed. For many Indians, who have poor access to hospitals or health clinics, CHR's are the primary providers of health care. Juanita Noah, a CHR for the Choctaw Tribe of Oklahoma, makes regular home health visits to members of her tribe. In the following letter, Noah describes the families she visits and the treatment she provides during an average day. The letter was addressed to Mrs. Nancy Reagan at the White House.

Mrs. Nancy Reagan
The White House
Washington, D.C. 20500

Dear Mrs. Reagan,

I live in a rural area three miles north of Red Oak, Oklahoma and I would like to relate to you the services I performed yesterday in my field of work.

At 7:45 a.m. I drove into Red Oak where I gave a weekly injection of Vitamin B12 to a man who has cancer. He has had treatment and the disease seems to be in remission at present. The B12 gives him energy and strength to keep going. Next I drove six blocks to my mother's home to pick up medication for two clients. The van driver delivered it there yesterday at my request. He had picked this up at the Indian Health Service clinic in Talihina while there on his regular route.

I then drove thirteen miles west to Wilburton, where I delivered vitamins to Vivian Dili, a full blood Choctaw and a retired nurses' aid. Vivian has tuberculosis at one time and follows a strict regimen to maintain good health. She is nearing seventy years of age, but swims three times a week, works part time at the county hospital and needs her vitamins.

I then drove a mile out of town to the home of Florence Ray, 82 years old, thin and frail, but active as a little brown wren. Florence has a heart condition and she needs medication to relieve swelling in her extremities. Florence is half Choctaw. She plays a piano, makes beautiful quilts, and raises a lovely garden of both vegetables and flowers.

By 9:00 a.m. I had driven 25 miles northwest to Quinton, in Pittsburg County. There I met Tad, another CHR, and together we drove ten miles more to Brooken, then up on the mountain near Lake Eufaula to Ruby Phillips' home. Ruby is in the last stages of cancer. Surgery and chemotherapy failed. She and her husband Rufus will have been married forty-nine years next October. They have no children. Sad, to me, but they are philosophical about it and dwell on the good life they have enjoyed together. Ruby has a chest tube for drainage. I assisted her to the bathroom, drainage bag and all, and bathed her while Tad changed her bed and tidied the room. Ruby's blood pressure was dropping and I doubt she will be there next Wednesday when I promised to return.

We then drove to Roxie and Joe's. Roxie had called Tad the night before, concerned about her blood pressure. She is 79, and has hypertension. Her blood pressure was not elevated more than usual. We checked Joe's, too, and he was fine. We headed back toward Quinton, leaving the highway at intervals as most of these people are out in the rural areas. You see, Choctaws are not reservation Indians and are just scattered in and among white people and they get along well.

After several other visits, we arrived at Bascom, where there is nothing but a small Methodist church and the pastor and his wife, Robert and May Sockey, both full-blood Choctaws. The Sockeyes were without medicine and both have elevated blood pressure. They promised to go to the clinic in McAlester tomorrow. After leaving the Sockeyes', we visited a full-blood Comanche. She married a Choctaw in 1919 and has lived in this area since that time. She is widowed now, 78 years old, tends a few cattle and is altogether independent. She was fine, her hypertension is well controlled; she enjoys our visits. One more stop in Quinton and Tad and I go our separate ways as I have a good hour's drive to my home. This is just an average day. Somedays I do less, some days more, whatever is needed. I enjoy my work and I know I do it well.

I do not know how you feel about Indians. Whether you think of us as "dirty stinkin' Indians" or as the "proud noble red man." Disregard that and think of us as people with a heart, soul and needs, the same as all other people. I have said all this in order to explain that the CHR program will end after next September unless someone intervenes. That is why I have written to you. I am asking you to discuss this matter with your husband and request that he reconsider before cutting our program for good. It is not only here in the Choctaw Nation, but all across the United States, the CHR's are at work. Our People need us.

Sincerely,
Juanita Noah
CHR's Overcome ...

Continued from Pg. 12

CHR elimination has been questioned in some congressional quarters. During budget oversight hearings by the House Interior and Insular Affairs Committee, Representative Douglas Bereuter (R-Nebr.) called the CHR's the "first line of preventive health on reservations." He termed the proposed elimination "shocking" and stated that the recommendation is "very damaging news to Indian reservations across the country."

During Senate hearings, Senator John Melcher (D-Mont.) of the Senate Select Committee on Indian Affairs called the CHR program "truly outstanding." Additionally, in the Committee's report on budget estimates for FY 1983, Select Committee Chairman William Conen (R-Maine) expressed concern over the Administration's recommendation, noting that "in the absence of this program, many Indians will simply be without access to any health services."

The Committee report states that "IHS has acknowledged that CHR provision of direct health care services (is) a critical element of the health care delivery team on many remote reservations. There is nothing to take the place of this program and such a void will result in serious gaps in the linkages between the Indian Health Service clinical programs and the Indian communities for which they were established to serve."

*Priorities and Economics*

Given the apparent support for CHR services, the question remains: Why was the program ever targeted for such a severe cut in the first place?

Dr. Joseph Exendine, IHS Deputy Director, explains that the cut was made as "a matter of priorities and economics" in a budget-slashing fiscal proposal. Exendine, a staunch supporter of the CHR program, also says there is a "basic misunderstanding" about the role of CHR's on Indian reservations.

When the program was established in 1969, CHR's were employed to "create a viable liaison between non-Indian professional staff and the Indian service population... to improve communications between providers and consumers of service."

From this limited beginning, the CHR program has evolved steadily toward the provision of direct patient care, Exendine says. He notes that of 2,100 CHR's presently employed by tribes, more than one-half are classified as "CHR Specialists" capable of providing treatment in a specific health area such as otitis media, emergency medical services, physical therapy, or mental health.

Exendine adds that CHR's continue to provide an important community-based element to the overall Indian health care system. "We can have the best physicians and the best facilities in the world, but without the proper liaison between the community and the hospital, the (health care) program just won't work," he said.

But even with these accomplishments, there are some federal and tribal officials that see a need for changes that would strengthen the program and prevent future "misunderstandings" about the role of CHR's. Such changes include, among others, the development of national program guidelines and a uniform reporting system for CHR activities.

Barry Snyder, chairman of the Seneca Nation in New York, which operates one of the most comprehensive tribal health programs in the country, says that a lack of IHS guidance has in some instances led to questionable utilization of CHR's, which has hurt the program's overall credibility. Snyder recommends that formal directions be established to assist tribes in the management of their CHR programs.

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CHR Task Force Recommends Plan for National Program Review

ALBUQUERQUE, N.M.—Unless Congress acts to counter a Reagan Administration proposal, tribally-based Community Health Representative (CHR) programs around the country will close their doors September 30. The Administration has recommended the elimination of the CHR program from the Indian Health Service (IHS) budget in 1983.

With time running out and congressional committees preparing for next month's FY 1983 budget markups, CHR directors are being asked to take part in a nationwide assessment to provide Congress with additional information about their programs.

Plans for the national survey were among several important topics reviewed at a meeting of a special "CHR Task Force" here June 21-24. The 10-member task force, comprised of IHS staff, tribal health personnel, and representatives from national Indian organizations, was established to assist IHS in responding to congressional requests and to develop recommendations related to the program's administration. In addition to task force members, the meeting was attended by approximately 50 individual CHR's from programs around the country.

The survey questionnaire was developed to accurately describe and record CHR activities. The survey was field tested on four tribes in Washington state and was found acceptable as a method for assessing the tribes' CHR programs.

Task force members are hopeful that enough data can be obtained from this assessment to respond to recent congressional requests about the program. The survey document will be distributed within a few weeks to appropriate tribal officials and CHR staff, with a final report scheduled for completion by August 31.

A second major item of discussion at the meeting centered on a recent IHS directive concerning future funding of CHR programs. According to the memorandum, which was issued June 8 to all IHS contracting officers, "the continued uncertainty of FY 1983 funding and the congressional evaluation requirement has imposed certain planning restrictions on IHS" and, therefore, all CHR contracts are to be funded only through August 31, 1982.

The memorandum continues that "when the program decisions have been made . . . funding will be provided on a case by case basis to either: (1) provide closeout funding through September 30, 1982 or (2) provide funding for the ongoing project into FY 1983."

Several attendees at the meeting questioned the intent of the memorandum and complained that some IHS contracting officers have interpreted it as a directive to begin closing out CHR contracts. The task force has requested that IHS issue an immediate clarification of the memorandum to avoid unnecessary confusion in the administration of CHR contracts.

(When questioned about this matter, one IHS administrative official familiar with the memorandum said it was not intended to shut down CHR programs. The official said that Congress has requested separate evaluations of urban, alcoholism, and CHR projects, with funding to be directed only to those projects found in compliance with contract and program requirements. The purpose of the memorandum, stated the official, is to provide instructions to IHS contracting officers while the evaluations are being completed.)

(However, the status of such a "case by case" evaluation of CHR projects remains unclear. According to one CHR task force member, the national CHR survey is designed to provide a description of each program, not an evaluation.)

CHR'S PROVIDE A kind of care that cannot always be fully described in health statistics and reports. Here, Daisy Damon assists Mrs. Glenhasbah Tsosie by fixing her hair. The question of recording and reporting CHR services, as well as assessing CHR activities nationwide, is presently under review by a national CHR task force.
Stronger Disease Prevention, Health Promotion Programs Urged for Indian Communities

TUCSON, ARIZ.— Over the past 25 years health conditions in most Indian and Alaska Native communities have changed dramatically. No longer are epidemics of tuberculosis and other disease commonplace on Indian reservations, and statistics clearly indicate significant improvement in some areas such as infant and maternal health care.

Yet the overall health status of American Indians and Alaska Natives remains intolerably lower than that of the general population. In particular, Indians are experiencing startling increases in diabetes, alcoholism, hypertension, cancer and heart trouble.

In attempting to treat these and other health care problems, Indian health officials have sought to strengthen the role of preventive and community health programs — including health education, outreach services, home health care, screening clinics, and nutrition services — in the overall Indian health care delivery system.

With a goal of further promoting preventive health measures as an important step toward improving the health status of Indian people, the National Indian Health Board (NIHB) pulled together some of the top professionals in this field to serve as faculty at the Fifth National Indian/Alaska Native Health Conference here April 19-22.

Attended by nearly 800 participants from around the country, the conference featured several noted Indian speakers who addressed different aspects of the conference theme, “Preventive Medicine — The Key to the Future.” The four-day assembly also included 24 separate workshops on topics related to preventive health services, legislation, and health administration.

During the opening general session April 19, three keynote speakers stressed the need for stronger personal and community involvement in the promotion of good health. The three speakers were Dr. Annie Wauneka of the Navajo Nation; Wendell Chino, Chairman of the Mescalero Apache Tribe in New Mexico; and Dr. George Ignace, Coeur d’Alene, of the Association of American Indian Physicians.

Dr. Wauneka, whose work over the years has been instrumental in improving health conditions on the Navajo Reservation, told conferees that existing Indian health programs have not succeeded in controlling preventable diseases in Indian communities. “The

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Stronger ...

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tragedy is that health problems which continue to harm, disable, and kill our people could be solved through preventive programs and basic public health measures."

Calling for an extensive re-evaluation of Indian health programs, Dr. Wauneka declared that "it is time to build prevention into the structure of our Indian health care system. We must become more concerned with health and wellness, and not just accept the treatment of disease and illness."

Indian health programs need a creative new approach to address the health care needs and living conditions of people in the community, "rather than simply following a Western medical model," she said.

Such an approach, she continued, should include preventive health services such as personal, family, and community health education; referral services for early diagnosis, screening and detection of disease; public health nursing; better sanitation services; improved personal hygiene; basic nutrition services; and special health programs for infants, young mothers and the elderly.

Additional preventive services can be provided through a home health care program, said Dr. Wauneka. "The program of prevention through home health care allows us the opportunity to take greater responsibility for the health of our own people and to train our own people as health workers."

Dr. Wauneka added that these services have not been emphasized by IHS, and that it will require a commitment from the Indian community to move their health programs in this direction. She urged conference participants to "take an active responsibility in caring for our own people rather than depending on the Indian Health Service system."

Similar feelings about the need for preventive services were expressed by Wendell Chino in his discussion of the role tribal leaders play in promoting good health.

In their positions as tribal administrators, Chino said, chairmen and council members can work with different federal and tribal programs to set up a coordinated network of preventive health-related services. And as elected officials they can use their leadership abilities to encourage community awareness and acceptance of those services, he said.

Chino told the audience that efforts by his own tribe, the Mescalero Apache, to develop specific health initiatives have resulted in the elimination of tuberculosis and improved health care for infants and mothers. He exhorted tribal leaders to review their existing health programs to insure that they are meeting the most pressing health care needs of their people.

Promotion of good health in Indian communities will benefit tribes in many ways, Chino said. "Good health for working men and women means better jobs and better income. When our Indian people are in good health they can accomplish anything they want."

"Crisis Medicine ... Very Costly"

Addressing preventive medicine from the perspective of the physician was Dr. Gerald Ignace, chairman of the Milwaukee Indian Health Board and a former medical officer on the Navajo Reservation.

Ignace said that from his experience as a physician he found that Indians generally seek medical care only in crisis situations. "Crisis medicine is a very costly way to go about becoming healthy," he asserted.

Especially disturbing is the sight of Indian children suffering from conditions that could have been prevented, Ignace said. "When we see these problems affecting our young people, the people that are the
Continued from Pg. 17

future of Indian Country, then it is doubly hard to

Ignace suggested a more efficient use of immunization as a cost effective approach for promoting better health among the young. Citing statistics that show the incidence of mumps and measles among Indian children to be much higher than the general population, he said: "This tells me as a physician that we are just not immunizing our people. Immunization has been proven to be a safe and effective measure for the prevention of infectious diseases, and it is certainly within our grasp to provide."

Ignace also pointed to alcoholism, accidents, diabetes, obesity, and heart disease as areas where preventive measures could sharply reduce major health problems, and even deaths, among the Indian population.

Indian communities should encourage and participate in health promotion, he said. "But more importantly," he added, "we as individuals must become more responsible for our own health. This is one area that doesn't cost any money — all it costs is effort on our part."

On the final day of the conference, Indian Health Service (IHS) Director Dr. Everett Rhoades told conferees of his intention to have "IHS move more strongly into new areas of prevention of disease and maintenance of health.

Rhoades, who assumed the position of IHS director February 1, said he was particularly interested in exploring ways to emphasize prevention in the area of alcoholism. "I want us all to get serious about the (alcohol-related) problem of family destruction, alienation, and self-destruction of Indian people, especially young Indian people."

With a stronger emphasis on preventive care, Rhoades predicted there will be an increasing need for tribal participation in the delivery of health services. "I might even suggest that we may need a worker who might be called, if you will pardon the expression, a 'community health representative'," he said in reference to the Administration's recommendation to abolish the Community Health Representative program in FY 1983.

Rhoades also alluded to the existing fiscal climate when he suggested to conference delegates that the issue of eligibility for services may soon have to be examined. He stated that "...the pressure upon us to define what an Indian is, at least perhaps for the receipt of various kinds of benefits, is no longer a long-range goal that can be put off into the future. My opinion is that it is on us at the present time."

In addition to the general assembly presentations, the conference featured 24 separate workshops that covered such topics as fetal alcohol syndrome, otitis media, environmental health, nutrition, diabetes, emergency medical services, cancer, rheumatic heart disease, end stage renal disease, and the medical aspects of alcoholism.

All general assembly and workshop presentations were tape recorded and are available for purchase. To request an order form, contact the National Indian Health Board, or write: American Audio Association; P.O. Box 511; Floral Park, N.Y. 11002. Phone: (212) 740-0186.
Phoenix Board Pursues Alternatives for Keeping Services

PHOENIX, ARIZ. — With budget cuts threatening to disrupt much of its program, the Phoenix Service Unit Indian Health Advisory Board (PSUIHAB) is seeking new ways to maintain an extensive array of health services for Indian people residing in Phoenix and eight outlying communities.

Although PSUIHAB's main objective is to serve a rural population, it offers its services to all Indian people who seek help, according to executive director Edgar Molleda. At present PSUIHAB manages an orthodontic clinic, an outpatient alcoholism program, the Guiding Star Lodge — an inpatient alcoholism program geared primarily to serve women and their children, a TB treatment and screening service, a Community Health Representative program, and a patient advocacy service within the Phoenix Indian Medical Center (PIMC).

The board also interacts with PIMC's management and key health professionals in an advisory capacity, says Molleda. The staff of the Medical Center routinely consults with the corporation's Board and management on matters of policy and procedures affecting patient care.

Recently, the two organizations have begun to explore the possibility of working more closely together to maximize health resources during a time of diminished federal funding. Dr. George Blue Spruce, Phoenix Area IHS Director, has been instrumental in encouraging this cooperative relationship, says Molleda. The Orthodontic Clinic, presently managed by PSUIHAB, is the result of this relationship.

The benefits, he says, are that IHS patients in at least seven Arizona communities continue to benefit from services which were discontinued in the later part of 1981 due to federal cuts, and the corporation gains additional experience in the management of health services.

Another joint venture launched earlier this year is an Eyeglass Program that offers eye care and a reduction in eyewear prices to all patients of PIMC. The program was developed in order to offer an alternative to patients who had been purchasing their glasses from private optical shops at regular retail prices.

Although the potential for profitable and mutually beneficial joint ventures between IHS and this Indian corporation is high, the drastic cuts in Alcoholism and CHR funding are seriously jeopardizing the existence of the PSUIHAB, Molleda says. The Board of the corporation intends to pursue more ambitious health related enterprises in order to ensure the continuation of health services to Indian people. At the present time, feasibility studies are being conducted to determine the profitability of various health related businesses which would eventually finance some of the health care of Indian people.

Additional information about the PSUIHAB and its services can be obtained from: Edgar Molleda, Executive Director; PSUIHAB; 4201 N. 16th St., Suite 260; Phoenix, Ariz. Phone: (602) 277-4767.

CHR's Overcome ...

Continued from Pg. 14

Another view of difficulties related to the CHR program is offered by Ada White, a CHR supervisor for the Crow Tribe in Montana and President of the National Association of CHR's. According to White, the CHR program has developed rapidly over the past 10 years, assuming many new responsibilities in community health care services, and has consequently experienced the "growing pains" found with other programs.

"Certainly, there have been problems. But they are not unique to CHR programs," White said. One such problem associated with the development of the CHR program, says White, is the internal conflict that sometimes arises between CHR's and other tribal health personnel, or IHS staff, that attempt to exercise their control over CHR activities. This kind of political infighting has only served to undermine the program's credibility, she said.

White also addressed the issue of patient transportation, a CHR activity that has drawn much criticism, including assertions that CHR's provide a kind of "taxi service" to reservation residents. The criticism has led some CHR programs, such as the Navajo Nation's, to prohibit patient transportation except in emergency cases.

White maintains that because of isolated living conditions on reservations, and the inability of some patients to drive long distances to health facilities, transportation is an important health-related service to the community. "We are still facing Third World conditions on many reservations," White explains. "If the reality is that people live 60 or 70 miles from the nearest health center, then you have to get them there."

Stanley Frost, CHR coordinator for the Southern Ute Tribe in Ignacio, Colorado, voiced similar feelings about patient transportation. "Even though we have a modern health clinic, it still takes the individual efforts of the CHR's to bring people into the clinics."

Efforts are underway to eliminate possible confusion over CHR activities and strengthen the program's overall accountability. A task force comprised of Indian representatives and IHS staff has been pulled together to assess the current status of the program, as requested by Congress, and to develop other recommendations (see related story on pg. 15).

Meanwhile, health providers and health consumers on reservations across the country nervously await the decision on the CHR program for next year. As expressed by White, "the removal of (CHR) funding for FY 1983 would eliminate a primary element in the total health care delivery system currently being operated by Indian tribes and Alaska Native corporations. The critical concern is the need for the continued provision of services in those areas of patient care not being met by other health care providers."

The fate of the CHR program will likely be decided later this summer, when Congress establishes federal budget priorities for next year. The House and Senate Interior Appropriations Subcommittees, which set spending levels for IHS programs, are expected to convene during July and August for their budget markups.
CHR Task Force...

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In addition to the national program assessment and the IHS memorandum, the task force reviewed a proposed CHR Manual containing a program description, definitions, objectives, training protocol and reporting requirements. After recommending several changes in the proposed draft, the group agreed to include the manual as part of a report that will be distributed to CHR programs for their review.

As for the future of the CHR program, the task force strongly supported its continuation and recommended: that IHS develop a national mandatory reporting system to record CHR services; that training be made an integral part of the CHR program; that clinical directors and CHR personnel be required to meet at least monthly; and that administration of CHR programs within IHS be more structured.

The task force also addressed the issue of its own makeup, which has drawn strong criticism from a number of CHR's and tribal health officials. Tanya Parker, who coordinates CHR activities for IHS, acknowledged that the question of tribal and CHR representation on the task force has been a controversial issue. However, she says, IHS budget limitations require that the task force membership be kept to a minimum.

Parker adds that the task force's work is only a starting point, since its recommendations are distributed to tribes or CHR contractors for comments. Given the existing constraints on time and resources, the appointment of a task force was considered the most effective approach for responding to congressional requests about the CHR program, she said. "Our only alternative was to develop the reports in-house and send them out to tribes. This way, at least we have some participation from the beginning."

Recommendations developed at the Albuquerque meeting, the task force's second, will be circulated in mid-July to tribes and CHR personnel, who will be asked to return their comments on the material by early August. A final report will be compiled by August 31.

Additional information about the CHR task force can be obtained by contacting Linda Standing at the National Indian Health Board office in Denver, Colo.; or Tanya Parker; Indian Health Service; Rm. 6A-55; 5600 Fishers Lane; Rockville, MD 20857. Phone: (301) 443-4644.

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