



# NIHB Health Reporter

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## Indian Health Programs Slated for Cuts Under Reagan Request

WASHINGTON, D.C.—The Reagan Administration's proposal for massive budget cuts in FY 1982 includes reductions in a number of federal programs that will adversely affect the health care services available to American Indians and Alaska Natives.

Under the administration's FY 1982 request, funding for the health services portion of Indian Health Service (IHS) budget will be reduced \$28 million from the level recommended by the Carter Administration, while funding for IHS hospital and sanitation construction would be slashed by \$109 million.

Two of the more significant cuts in the IHS health services budget are a \$4.5 million reduction in the urban Indian health program — which provides all or partial funding for 41 urban Indian health projects across the country — and a \$1.9 million decrease in the IHS health manpower scholarship program. The Reagan Administration is further recommending that both these programs be phased out entirely over the next few years.

The proposed reduction and elimination of these two programs, which were both initiated under the Indian Health Care Improvement Act (P.L. 94-437), received particular attention from members of the Senate Select Committee on Indian Affairs during the Committee's oversight hearing on the FY 1982 budget here March 23.

Responding to questions from the Committee about the proposed phase-out, IHS Director Dr. Emery Johnson explained that while both programs have been very successful it is the Administration's position that funding for these programs will be available from other federal and state sources.

However, Senator John Melcher (D-Mont.) pointed out that programs such as these were originally established because Indian people did not have adequate access to alternative funding sources. Chairman Senator William Cohen (R-Maine) also voiced his concern that alternative health programs, which are being reduced at least 25 per-

*Continued on Pg. 3*



SEN. SLADE GORTON (R-Wash.) (left), Sen. William Cohen (R-Maine) (center), and Sen. John Melcher (D-Mont.) (far right) of the Senate Select Committee on Indian Affairs listen intently to witness during March 23 oversight hearing on the Administration's budget proposals for Indian programs. Witnesses from the Indian Health Service, the Bureau of Indian Affairs, the Department of Housing and Urban Development, and the Department of Education testified before the committee on the effects the proposed Administration budget will have on Indian programs.



# Health News Across the Nation

**The following is a regular feature of the NIH Health Reporter. In this section, we present our readers with short, concise 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. Further information on items mentioned here can be obtained from the NIH Public Information Office.**

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WASHINGTON, D.C.—The National Tribal Chairmen's Association (NTCA) will hold a meeting here May 6-7 to examine budget cuts proposed by the Reagan Administration, and to develop national position statements on a number of important issues related to the budget. The meeting will be held at 1701 Pennsylvania Ave., NW. For further information, contact: National Tribal Chairmen's Association; 1701 Pennsylvania Ave., NW; Washington, D.C. 20002; Phone (202) 343-9484.

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WASHINGTON, D.C.—The Census Bureau has issued a preliminary report that the 1980 census count for American Indians and Alaska Natives was 1,418,195. The figure represents an increase of approximately 70 percent over the 1970 recorded population of 827,268. More detailed information on the 1980 Census is expected to be released later this year.

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ALBUQUERQUE, N.M.—“The Indian Family — Foundation for the Future” is the theme for the Third National Indian Child Conference, which will be held here May 17-21. According to conference chairperson Effie Dressler, the conference has four major purposes: to identify problems affecting American Indian children; to identify specific cost-effective programs to address these problems; to implement and expand such programs; and to create a strong advocacy force for Indian children. For additional details about the conference, contact: Dallas Johnson; Save the Children; P.O. Box 4010; Albuquerque, N.M. 87196.

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ALBUQUERQUE, N.M.—The American Indian/Alaska Native Nurses Association will hold its Seventh Annual Conference here April 25-28. The theme for this year's conference is “Environmental Change: The Effects on the Health of the American Indian/Alaska Native Community.” Conference activities include tours of the Santa Fe Indian Hospital and the Los Alamos Scientific Laboratory, and presentations by Ellouise DeGroat and Dr. Annie Wauneka, who will speak about their recent experiences in China. For further information on the conference, contact: Janice Kekahbah, Director; American Indian/Alaska Native Nurses Association; P.O. Box 1588; Norman, Okla. 73070.

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WASHINGTON, D.C.—Sen. Dennis DeConcini (D-Ariz.) recently introduced a bill that would provide legislative authority for Indian tribes and local governments to enter into agreements regarding regulatory authority and civil and criminal jurisdiction. The bill is similar to a measure

that has twice been passed by the Senate, but has not yet been approved by the House. According to DeConcini, the bill — entitled the “Tribal-State Compact Act of 1981” — will “help to reduce the existing barriers between tribes and local government units, thereby creating an atmosphere for cooperation between the various parties.”

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AURORA, COLO.—The Association of American Indian Physicians (AAIP) will hold its annual meeting here July 23-24. The meeting will focus on the effects of alcoholism and alcohol abuse among the Indian population. Two of AAIP's own authorities in the field of alcoholism, Dr. Leslie Collins and Dr. Ralph Dru, and nationally known Indian leaders in the alcoholism field will participate in the annual meeting. For further information contact William Wilson, Executive Director; Association of American Indian Physicians; 6801 S. Western, Suite 206; Oklahoma City, Okla. 73139. Phone: (405) 631-0447.

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WASHINGTON, D.C.—The White House announced March 17 the appointment of Morton C. Blackwell as special assistant to the President for veterans, fraternal organizations, and Indian groups.

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WASHINGTON, D.C.—The National Tribal Chairmen's Association (NTCA) has received a grant from the Indian Health Service to produce two filmstrips aimed at encouraging Indian students to pursue health careers. The filmstrips will include information about educational requirements, scholarships, financial aid, and training programs. NTCA will distribute the filmstrips nationwide to high schools with large Indian enrollments, tribal representatives, and Indian organizations that use health careers recruitment materials.

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SAULT STE. MARIE, MICH.—The Inter-Tribal Council of Michigan recently conducted its second training course in substance abuse for Indian health professionals. The college accredited course provides persons from a number of health-related fields with a background in the treatment of problems related to substance abuse. Additional information on the program can be obtained from John Frisch; Inter-Tribal Council of Michigan; 405 E. Easterday Ave; Sault Ste. Marie, Mich. 49783.

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SPOKANE, WASH.—The National Congress of American Indians (NCAI) will hold its mid-year convention here May 27-29. For further information, contact: Ron Andrade; National Congress of American Indians; 202 E. St., N.E.; Washington, D.C. 20002. Phone (202) 546-1168.

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*Continued on Pg. 3*



Continued from Pg. 2

RENO, NEVADA—The Inter-Tribal Council of Nevada announced its plans to open a residential alcoholism treatment center here. The facility will provide comprehensive counseling and treatment services for alcohol abuse, and will be open to male and female patients over the age of 16.

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PHOENIX, ARIZ.—The American Indian Training Institute will sponsor the Fourth National American Indian School on Alcoholism and Drug Abuse here April 26-May 1. The meeting will feature a number of workshops designed to examine many of the current issues related to alcoholism. For further information, contact: Dave Vallo; American Indian Training Institute; 2222 Watt Ave., Suite B-4; Sacramento, Calif. 95825.

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FORT HALL, IDAHO—The Idaho Inter-Tribal Policy Board announced the start of a new project that will provide training opportunities to Idaho Indians in three entry-level health occupational areas: Patient Care (nurse's aide, orderly, etc.), Food Services (production and preparation), and Environmental Maintenance (housekeeping and clinical cleaning). The project is intended to develop economic self-sufficiency and employment potential, and to improve the quality of health care for Indian people through the training and education of Idaho Indian health para-professionals.

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BRIGHAM, UTAH—The first Indian Social Workers Training Institute will be held here the week of June 21 at the Bureau of Indian Affairs Office of Technical Assistance and Training. According to Evelyn Lance Blanchard, President of the Association of American Indian and Alaska Native Social Workers, the purpose of the institute is to provide professional training in the new field of Indian social work.

Blanchard says that the institute is the first attempt in examining contemporary Indian social work practice, which she contends will help develop a broader framework in Indian and Western thought. Also offered at the training will be the study of the compatibility of Western psychiatric and psychological theories and Indian thought; crisis intervention therapies, and political involvement. For further information, contact: Dan Edwards; Graduate School of Social Work; University of Utah; Salt Lake City, Utah 84112.

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WASHINGTON, D.C.—The Community Nutrition Institute's (CNI) Training Center will conduct a four-day workshop on the Older Americans Act nutrition program here April 27-30. The workshop will cover all major aspects of operating a project, incorporating the most recent legislative and regulatory developments. For further information contact Jo Weinstein at CNI, 1146 19th St., N.W., Washington, D.C. 20036; phone (202) 833-1730. ■



*IHS DIRECTOR DR. Emery Johnson testified before the Senate Select Committee on Indian Affairs about the effects of proposed cutbacks in the FY 1982 IHS budget. Much of Johnson's testimony centered on proposed cuts in the areas of Indian health manpower programs, urban Indian health projects, and sanitation facilities construction.*

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## Indian Health . . .

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Continued from Pg. 1

cent by the administration, might not be capable of providing health care to Indians needing services.

Senate Committee members also expressed concern over apparent inconsistencies in the President's proposed reductions for Indian housing.

As explained by James Canan, Acting Deputy Assistant for Indian Affairs, federal construction of Indian homes is carried out under a tri-agency agreement between the Department of Housing and Urban Development (HUD), the Bureau of Indian Affairs (BIA), and IHS. HUD provides funding for construction of the home; BIA funds the construction of access roads and streets; and IHS provides funding for water and sewage facilities.

The Reagan budget request for FY 1982 contains no new HUD monies for the construction of Indian homes, according to George Hipps, Acting Deputy Assistant Secretary for Housing. However, Hipps told Committee members, HUD has funds available from prior years and plans to construct approximately 12,000 Indian homes over the next four years.

Under questioning by Committee Chairman Cohen, it was determined that the proposed IHS FY 1982 budget contained no funding for sanitation facilities, and that IHS would be unable to provide water and sewage hookups for future HUD homes. Johnson told the Committee that the IHS budget was prepared under the assumption that there would be no new Indian housing in FY 1982.

In addition to the elimination of funding for water and sanitation facilities (a reduction of \$73 million from the Carter budget), the Reagan FY 1982 budget request for IHS recommends a \$36 million reduction for the planning and construction of three hospitals (Kanakanak, Alaska; Crownpoint, N.M.; and Browning, Mont.) and three outpatient health clinics (Anadarko, Okla.; Tsaile, Ariz.; and Huerfano, N.M.).

Continued on Pg. 4



# Notes From the Executive Director:

The National Indian Health Board recently completed its Fourth National Indian/Alaska Native Health Conference in San Diego, Calif. The Board of Directors has now received recommendations from conference participants and will be acting on those recommendations in the coming months.

NIHB will continue working with all national Indian organizations, tribes, and inter-tribal organizations, to assist them in fulfilling their ambitions of making improvements in the health field. We have said on many occasions that if we are intending to rebuild our Indian Nations economically, we must have healthy people. The level of our health care must be raised to a level that is at least equal to the national average.

NIHB has testified during the past few months before several congressional committees, educating and informing those members of Congress about the still deplorable health conditions that American Indians and Alaska Natives must live with due to lack of sufficient funding. Piecemeal funding will never adequately address this problem.

The present Administration contends that many of the proposed budget cuts are being requested in an effort to improve management and eliminate waste. This is certainly a desirable goal. I believe we are all interested in good and efficient government, and that is what many of us are striving for.

But these proposed budget cuts must be carefully examined to determine their impact on services to the truly needy. Many of the proposed cutbacks for Indian Health Service and other agencies would have serious consequences for contract health care, health education, urban health care projects, Indian housing, and many other areas affecting health care services for Indian people.

The National Indian Health Board will continue to monitor the Administration's budget proposals, and we will keep you informed of their impact on health services for Indian people. We also encourage you to write us and let us know how these proposals are affecting your health programs. We'll do whatever we can to help.

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## Indian Health . . .

*Continued from Pg. 3*

Funding would be provided for the completion of the Indian hospital at Tahlequah, Okla. (\$7.9 million) and for technical energy studies (\$200,000).

Other cuts in the IHS health services program — in addition to the reductions for urban Indian health care and Indian health manpower scholarship — include contract medical care (\$5.9 million); medical supplies (\$1.3 million); Community Health Representative and Alaska Community Health Aides programs (\$776,000); manpower training (\$535,000); mental health (\$1.8 million); hospital and health clinics (\$2.7 million); and tribal management (\$285,000).

In total, the Reagan FY 1982 budget request for IHS recommends \$626 million in health services and \$8 million in facilities construction, compared to Carter's request of \$655 million for services and \$116 million for construction.

President Reagan's proposed budget will also decrease a number of other programs that provide health services to

Indian people. These recommendations include placing a spending limit on Medicare and Medicaid; reductions in the Women, Infant, and Children's (WIC) program, Food Stamps and other nutrition program reductions; a cutback in the CETA employment program, which provides tribes and IHS with a number of employees; a phase-out of the National Health Service Corps; elimination of the U.S. Commission Corps; and closure of Public Health Service marine hospitals.

In addition, President Reagan is proposing consolidation of more than 40 health and social services programs into four block grants to state governments. The Reagan block grant plan currently has no provision for direct funding to tribes and tribal organizations. Tribal groups received approximately \$15 million under these programs in FY 1980.

Under the Reagan block grant proposal, federal health and social services would be merged into one of four grants: health services, preventative health, social services, or energy and emergency assistance. Funding for the block grants would be reduced 25 percent over current program levels, then distributed to the states under existing statutory formulas. Administration officials hope to implement the block grant program by October 1, 1981.

The Reagan budget proposal for FY 1982 was submitted to Congress March 10, and it is expected to be several months before Congress completes its work on the request. ■

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# NIFNRC Symposium Stresses Need for Nutritional Self-Sufficiency

LAS VEGAS, NV.—Although the spectre of President Reagan's sweeping proposed budget cuts in the area of nutrition generated much discussion, it was the need to rediscover traditional Indian foods and to return to a substantial degree of nutritional self-sufficiency that emerged as the recurring theme throughout the National Indian Symposium on Food and Nutrition held here March 9-13.

The symposium, hosted by the National Indian Food and Nutrition Resource Center (NIFNRC), focused primarily on providing participants with a legislative update and presentations in the areas of community food and nutrition programs, elderly nutrition, food distribution and urban Indian nutrition programs. Also presented were workshops focusing on the return of traditional Indian foods in the food distribution programs, Alaska Native Subsistence issues and identification of urban and rural food and nutrition needs.

The NIFNRC, in existence for two years, works for improved access by Indian and Alaska Natives to federal food programs and offers training and technical assistance to tribes and urban Indian groups in the hope of increasing their knowledge or control of food programs.

In its continuing role as an advocate for Indian nutrition needs, NIFNRC's second conference on food and nutrition also offered introductory and advanced training in specific federal nutrition programs such as food distribution, food stamps, nutrition education, elderly nutrition, and legislative awareness and strategy.

Speaking on legislative issues pertaining to Indian nutrition, Ron Andrade, Executive Director of the National Congress of American Indians (NCAI) said the federal nutrition programs are faced with an additional cut of \$700

million in federal food and nutrition spending, including funds earmarked for Women, Infants and Children (WIC) programs and summer free lunch programs.

Andrade also urged the symposium participants to collect data from their tribes and organizations so that they could fight back with information. "Only the Indian people can relate problems concerning nutritional service delivery systems and we need that data to explain. If we don't communicate with each other, we will have no one else to blame but ourselves."

Elementary and advanced workshops in food distribution programs provided information on application processes, financial matters and tribal obligations to recipients. According to Robert Price, Director of the Food Distribution Program for the Papago Tribe and the Chairman of the NIFNRC Board of Directors, the number of tribes that have become involved in administering their own food distribution programs has almost doubled since 1979. Several of the problems experienced by the small tribes, says Price, are directly related to the lack of transportation to isolated communities. Other problems expressed dealt with the need for a better food package — preferably a package with less salt, sugar and fat content; improved labeling on packages; the unavailability of special diets, and the need for creative programs in nutrition education.

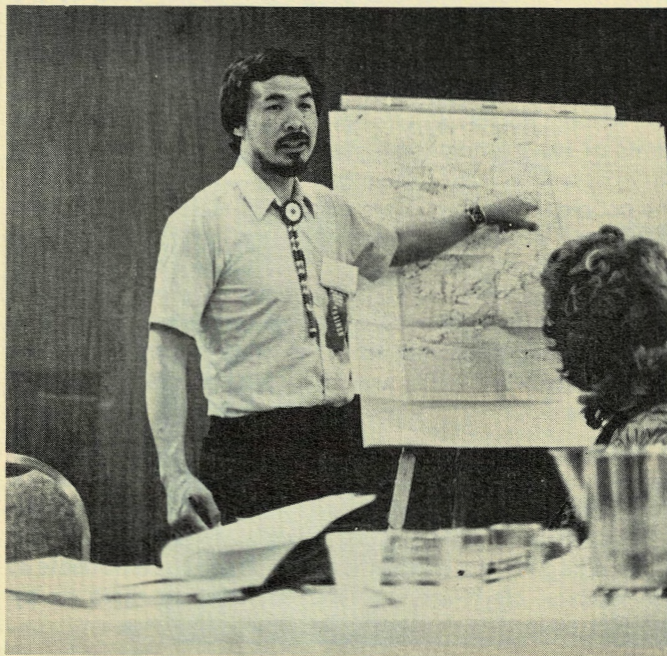
The Urban Indian Program Workshop revealed new and exciting nutrition services offered in an urban Indian health clinic setting. Workshop participants were provided with information from Seattle Indian Health Board (SIHB) Executive Director Luana Reyes.

SIHB's nutritional services are provided by a nutrition coordinator, a nutrition technician, a cultural food program liaison and advocate and a WIC dispatcher. The nutrition coordinator also provides consultant services for medical, dental, alcoholism and mental health programs, the diabetic breakfast, prenatal team, chronic disease team and elders group. The nutrition technician is responsible for the nutritional component of the adolescent health care team, providing clinical and school outreach health assessment, summer farmer's market, and meal planning for the alcoholism half-way house.

According to Reyes, the SIHB's nutritional services have continued to expand as the needs of the patient population have been identified. Reyes added that she is particularly proud of their program called ORKA, a Lummi word meaning "Whale." The program has three parts, said Reyes; a self-help project; a buying club/trade center; and an Indian coalition.

"We are re-training people to gather, prepare, and store traditional foods that are native to the Northwest," said Reyes. "The classes are free and we use the elders to teach people how to gather, cook and preserve traditional foods such as salmon, shellfish and berries."

The trend toward nutritional self-sufficiency and independence was further evident in the presentation of the Navajo Nutrition Self-Help Project (NNSHP), administered by the Navajo Tribe Food and Nutrition Service and the Office of Navajo Economic Opportunity.



*RALPH ELUSKA, Fisheries Director for the Alaska Native Foundation, describes to the Alaskan Subsistence Workshop attendees the efforts being made by Alaska Native organizations to restore native fishing and whaling rights.*

*Continued on Pg. 11*



THE IMPORTANCE OF Community Health Aides (CHA's) to the health care delivery system for Alaska Native villages was emphasized at the statewide Alaska Native health conference last fall. Pictured here are the Community Health Aides that were honored at the conference as the most outstanding CHA's from their respective regions.



# Community Health Aides Alaska Native Health

***The problem of delivering adequate health care services in Alaska Native villages is compounded by the vast distances between communities and medical facilities, severe weather, and the remoteness of many of the villages. Because of these conditions, Alaska Native villages rely on the local Community Health Aide for most of their primary health care. The Alaska Community Health Aide is selected by the village, employed by a local native health corporation, and trained in many aspects of medical care. Due to the isolation of many villages, the Community Health Aide often functions as the sole health provider for the community.***

***In the following article, Stephan Levinson, Susan Cook, and Priscilla Longshore review the role of the Community Health Aide in the Bristol Bay Area, which is comprised of 32 villages in a 40,000 square mile area in southwest Alaska. The authors credit the work of Bristol Bay's Community Health Aides as the primary reason for the improved health care among Alaska Natives in the region over the last fifteen years. We invite readers' comments on their discussion of this unique health care program.***

DILLINGHAM, ALASKA—The Bristol Bay area is a boomerang-shaped piece of the Bering Sea Coast that would be unremarkable if it didn't have some of the most exquisite scenery in the world; if it wasn't the home of the world's most productive salmon fishery; and if it wasn't the size of Ohio with less than 15 miles of paved road.

Less than 15 years ago the health status of the people in Bristol Bay could be compared to that of the United States in about 1900. At the same time that this country was making plans for putting men on the moon, there were problems getting penicillin in Bristol Bay. Bristol Bay, and most of rural Alaska, does not attract doctors and nurses to live and work there.

Because of these problems, the people of Bristol Bay revived the tradition of taking care of themselves. The

Community Health Aide program was utilized to serve their villages. These aides are called by several names — Community Health Aides, Health Aides, C H A's — but they are called when they are needed and they come right away because they live in each of the villages.

Each Community Health Aide is chosen by the people of the village, through a Village Council which governs the village. Training is provided by the Indian Health Service and by the Bristol Bay Area Health Corporation, a consumer controlled, consumer initiated regional service organization that provides all of the health care to the people of Bristol Bay through an integrated system of practitioners whose foundation is the Community Health Aide.

When a person is ill in a village, they come to the village clinic or send a family member for the Community Health Aide, who does make house calls. The clinic itself is built by the people of the village, sometimes using grant funds from the State of Alaska, sometimes supported by general obligation bonds, and sometimes, as in the Village of Chignik Lake, built privately by community members who care enough to want to help themselves. The Indian Health Service leases the clinics from the village for the use of the Community Health Aide and for visiting doctors on annual field trips.

Once a year a doctor visits each village, weather permitting, from the Bristol Bay Area Hospital in Dillingham. That is the only time that a Health Aide actually sees a physician in person. Daily contact is made for referrals, questions, problems, and making appointments at the hospital clinic by means of short wave radio or by satellite telephone — again, weather permitting.

This means that a Community Health Aide is an independent and trusted health care practitioner. Much of the time there is simply no one else available, and even then only by radio or at the end of a very bumpy airplane flight.



The Health Aide is also supported by mid-level practitioners who act as Field Coordinators and make additional visits to the villages at least once each year or on demand if the need arises.

In most villages the Health Aide has an alternate, although she is frequently less trained and less experienced. This means, of course, that a Health Aide is on duty or on call 24 hours every day, 7 days every week. The Community Health Aides are the most critical part of a health care network that stretches from the Alaska Peninsula and the Bering Sea shores to the hospital in Dillingham, and through there to Anchorage, Seattle, San Francisco and Houston, where referrals are made to tertiary care centers for patients.

In Bristol Bay there are 35 Health Aides, backed by three mid-level practitioners and three physicians; all to serve an area as large as Ohio and over distances of more than 300 miles from the central point. The closest comparison that can be made is to the "Barefoot Doctors"

people in our region and efforts are now underway to eliminate our new enemy.

Bristol Bay has recently added village-based alcoholism counselors who are being trained to deal with the number one health problem — alcoholism. Alcohol is implicated in virtually every accident, over 95% of deaths, and complicates nearly all illnesses in the Bristol Bay region. Before the end of 1981 there will be trained alcoholism counselors in every third village, each caring for their own village and two others to provide the necessary intervention to break the cycle of alcohol that decimates our people. By 1985 the goal is to have a counselor in every village.

Local people have also been trained in Cardiac Pulmonary Resuscitation (CPR), first aid, and other life saving measures. The trainers are local people who were chosen by their villages to receive the training. Now a core of local people have begun training in the principles of accident prevention, hunter safety, home safety, environmental pro-

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## ***an Integral Part of Care Delivery System***

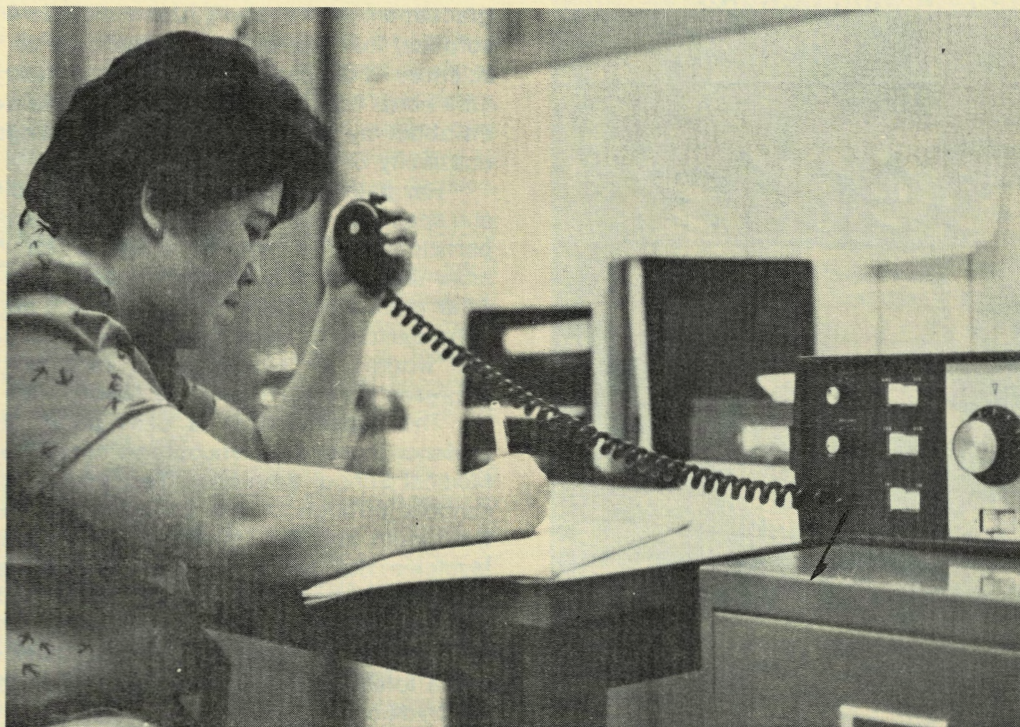
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of China, and even then, China has roads and cars for transportation.

The old enemy in Bristol Bay used to be tuberculosis, and only an active public health campaign helped to defeat and lower the incidence of active TB, so that it is now only a minor and rare problem. Alcoholism has now replaced tuberculosis as the number one killer of Eskimo, Aleut and Indian

tection and basic principles of epidemiology, so that we can attack accidents before they get to the stage where first aid is needed. In other words, prevention is the strategy and it is where we have decided to "invest" the limited resources that are available to us for anything except direct medical care.

*Continued on Pg. 9*



*RADIO COMMUNICATIONS PLAY an essential role in the work of Community Health Aides in Alaska. Because of the remoteness of most Alaska villages, Community Health Aides must rely on radio communication with physicians that are often hundreds of miles away. Pictured here is Ellen Etuckmelra, Community Health Aide in Aleknagik, Alaska.*



# Navajo Medical Student Seeks to Treat the 'Total Patient'

ALBUQUERQUE, N.M.—Treating the total patient, not just the disease, is a philosophy rapidly gaining acceptance in today's medicine. But to Susie John, a 27-year-old medical student, it is a concept that dates back many generations and is as natural to her as her Navajo heritage.

Now in her last year at the University of New Mexico School of Medicine, John says that the study of Western medicine has taught her a considerable amount about disease, but that her background as a Navajo has taught her to consider the total mental and physical health of a person.

"The Navajo's view of the world is like a big circle where everything is connected. If an illness befalls someone, that person is out of harmony with the environment."

According to John, Western medicine concentrates on where an ailment or sickness originates. "In school we are being trained to look at human organs instead of really considering what the patient's feelings are. We are not looking at what is happening to them in relation to their emotional and physical surroundings."

The emotional and physical surroundings that influenced this young Indian woman center around her traditional Navajo upbringing in Beclabito, New Mexico, a tiny hamlet outside of Shiprock. One of five children, John was raised in a traditional Navajo hogan, built of wood with an earthen floor.



*DURING HER ROUNDS at the Veterans Medical Center in Albuquerque, Susie John comforts a patient from Santa Fe, N.M., who was diagnosed as having a crippling neurological disease called basal ganglia. All fourth year medical students at the University of New Mexico take a four-week clerkship in either Neurology or Neurosurgery inpatient and outpatient care as part of their curriculum.*

"Beclabito consists of a trading post, a day school and approximately 200 people living within a 5-10 mile radius. My family and I lived in the hogan winters and summers and another house during the spring and fall — both homes having no heat or electricity," says John.

Her emotional upbringing also influenced her considerably. "My parents never went past the fifth grade. I was raised in a large, extended family where they let us be independent and we had to learn life the hard way. My role model was my mother who is strong, independent and courageous. My family also encouraged me to do whatever I wanted, no matter what it was."

John's independent and free-thinking spirit led her to taking an after-school job in a local mortuary. There, a curious pathway and interest into the mysterious wonders of life, death and healing began to unfold. "At the mortuary I had time to think — especially about why people would entrust their lives to doctors, thinking they had some special knowledge or blessing to heal people."

More probing thoughts and questions arose while the young Navajo woman cleaned the chapel and sanctuary at the funeral home. Her repeated exposure to the realities of death and the fragility of life continued to open up her interest in medicine and the art of healing. "I used to get the feeling that there was something about medicine that people held sacred, and I decided then to find out what it was."

John proceeded to enroll in Ft. Lewis College in Durango, Colo., even though she received no encouragement from high school counselors to attend college after graduation. At Ft. Lewis, John discovered, much to her surprise, that she was in the top third of her class in the sciences. "I did particularly well in chemistry and would get little notes from my professor saying he would like to see me about my future plans. It was then I began to realize the possibility of going into medicine."

Her pathway into medicine continued to unfold when she spent two summer vacations at Harvard University as a participant in a special program for financially disadvantaged minority students interested in health careers. After graduating from Ft. Lewis with a degree in biology, John decided to learn more about the health service field and worked for eight months as a Community Health Representative (CHR) for the Navajo tribe.

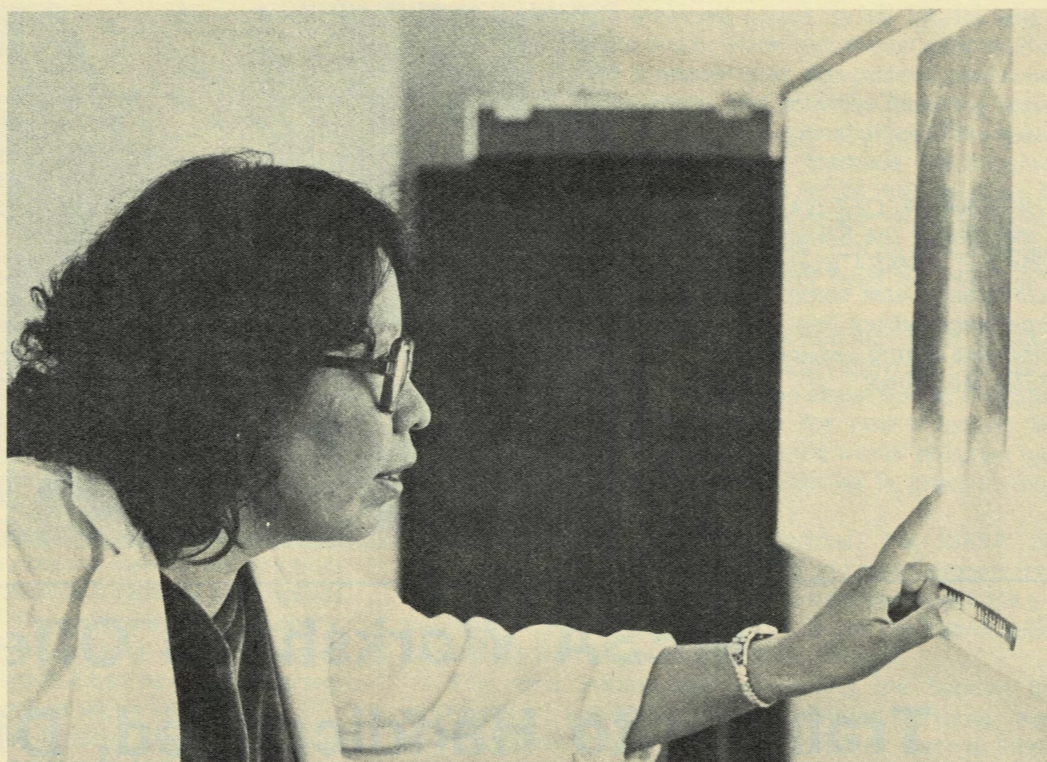
The experience as a CHR proved to be the final evidence needed to encourage her to take the difficult Medical School Admission Test and to apply to medical schools throughout the country. She was accepted at Dartmouth and the University of New Mexico School of Medicine, but decided on the school in New Mexico. The funding for her college and medical school has been provided by the Navajo tribe, says John.

Upon entering medical school, John was introduced into a totally alien environment. Feelings of not fitting into the traditional medical student mold while interacting with students from different cultural backgrounds and education experiences began to surface. But even with the cultural and societal differences, John continued to attend the

*Continued on Pg. 9*



ONE OF SUSIE'S favorite clinical areas is radiology. While taking a clerkship in neurology, she takes time out here to examine a spinal injury of one of her patients.



## Navajo . . .

*Continued from Pg. 8*

classes and stick to the study schedule, which amounted to 12 hours a day.

Her first and second year of medical school consisted of studies in the normal and abnormal functioning of the human body as well as lectures, lab work and the introduction to clinical science experiences.

The third and fourth year of medical school were more enjoyable, says John. Her studies and focus in the last two years involved a series of clerkships in areas such as psychiatry, surgery, pediatrics, obstetric-gynecology, neurobiology, surgical subspecialties, direct patient-care and a preceptorship, which requires a medical student to spend four weeks with a practicing physician in New Mexico.

John spent her four week preceptorship in a Shiprock hospital seeing patients in both the pediatric and adult hospital wards. "My preceptorship was an important experience. I was responsible for overall patient care, physical examinations, diagnostic plans and medical prescriptions. The stay in Shiprock was most enjoyable because I was able to fall back on what I had learned from the last three years," said John.

After graduating from medical school this July, and receiving the honor of becoming the first Navajo woman to graduate from the University of New Mexico School of Medicine, John plans to begin a three-year residency in pediatrics with the Three-Affiliated Hospitals program in Phoenix, Arizona.

"I will continue to work and treat Indian people," says John, "and to emphasize a correlation between Western and traditional Indian medicine. The reason for emphasizing this correlation is because when an Indian person is ill, there is always a decision whether to choose traditional medicine or go to a Western doctor."

John explains that when she first sees an Indian patient, she tries to establish how they feel about traditional

medicine and then proceeds to offer them options in both healing systems.

Back home in New Mexico, the John family children have been greatly influenced by the young medical student's growth and maturity since entering the Western technological world.

"My two-year old niece wants to become a doctor like her Aunt Susie. She keeps a stethoscope wrapped around her neck and even insists on taking a black bag to school with her," says John. "If you are not aware of all the opportunities open to you, you can never consider them." ■

## Community . . .

*Continued from Pg. 7*

There is no serious problem with drug abuse in Bristol Bay at this time, with the exception of isolated pockets, so resources in this area are devoted to a prevention program that emphasizes recreational activities; survival skills for rural living; and pride in traditional ways of culture, crafts, artwork, and government.

All of these services are coordinated through the Bristol Bay Area Health Corporation, which reports regularly to its Board of Directors to seek advice on how to proceed and what kinds of changes or new programs are needed or wanted in the villages. Each village selects a representative to this Board, and all 32 members vote on the issues.

If the health status of the people in Bristol Bay 15 years ago was equivalent to that of the United States in 1900, then today they have advanced to somewhere around 1945. Nearly half a century in 15 years is a remarkable advance. We plan to bridge the remaining gap in the 1980's through the use of Community Health Aides, physicians assistants, nurse practitioners, village based alcoholism counselors, locally trained accident prevention coordinators using locally developed methods and classes, regional emergency medical service networks, with the consumer board making the critical decisions about what directions to take in these vital areas of our lives. ■



*THERESA VALDEZ GARDNER, a member of the Shoshone tribe and a MESA workshop facilitator, relates some of her experiences about her blindness during session at MESA workshop.*



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## MESA Workshops Offer Training to Handicapped, Disabled

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DENVER, COLO.—All too often benefits of disabled rights litigation and legislation have not reached handicapped Native Americans. To address this problem, a series of ten workshops are now being conducted throughout the country by the MESA Corporation.

MESA, an Indian-owned company that provides consulting and technical assistance services to the disabled, was awarded a contract by the Administration for Native Americans and the Office for Civil Rights to conduct a series of training workshops on Section 504 of the Rehabilitation Act of 1973.

The objective of the MESA Project 504 is to train the disabled, parents of the disabled, advocates, tribal leaders and recipients who provide services to Native Americans, on the different aspects of Section 504.

Regulations implementing Section 504, according to Carmelita Thomas, MESA Project Manager, were issued by the Department of Health, Education and Welfare in June of 1977. These regulations were designed to accommodate the special needs of disabled persons through the elimination of architectural, communication and attitudinal barriers. Any agency or organization receiving federal financial assistance is required to provide equal opportunities to qualified handicapped persons in the areas of employment, aids, benefits and services.

In February, MESA held its fourth workshop here, providing attendees with an analysis of Section 504, a complete review of the Civil Rights Act of 1964 and information related to grievance procedures, coalition building, resource sharing and technical assistance.

### **Rights Under Federal Laws**

Speaking for the U.S. Department of Education regional office in Denver, Mike Lopez explained the legal definitions of a handicapped person. According to Lopez, a handicapped person is one who: has a physical or mental impairment which substantially limits one or more major life

activities; has a record of such an impairment; or is perceived as having such an impairment.

A handicapped person does not necessarily have to have a "visible" handicap, said Lopez. Persons with non-visible disabilities such as diabetes, epilepsy, mental illness, and alcoholism or drug addiction are also considered handicapped according to the law. "These qualifications," says Lopez, "mean that any Native American or other person who has a mental or physical condition that limits one or more of his or her major life activities, such as walking, hearing, seeing, talking, breathing, learning, caring for oneself, performing manual tasks or working, could qualify as a handicapped person."

One main purpose of the two-day training workshop was to familiarize handicapped people and other attendees with the details of Section 504 and how the laws can be used. Specific examples given throughout the workshop on what rights an Indian person might have according to Section 504 included:

— *Employment* — a handicap should not matter unless it keeps a person from doing a good job. Employers must consider only training, experience and how well the job is done. In some cases, an employer may have to change job duties or provide aids such as ramps and special equipment to help a handicapped person do the job.

— *Medical and Social Services* — A handicapped person has the right to take part in programs offered to the public in his/her community regardless of the handicap, if otherwise qualified. Such programs include public health clinics, recreation centers, vocation rehabilitation centers and schools.

— *Education* — A handicapped child is entitled to a free, appropriate, public education regardless of the handicap. School programs must meet the needs of each child so that they can improve strengths and reduce dependency.

*Continued on Pg. 11*



*Continued from Pg. 10*

As part of the Section 504 training, MESA also incorporated sample case studies that would help the attendees see into the practicality of the law. One case study concerning alcoholism more than adequately provided insights and corrective actions that could be taken. The study cited Suzanne, a 33-year old Native American housewife, who often has a few drinks during the day and passes out. One afternoon, while grocery shopping, she fell in the middle of an aisle and suffered bad bruises and cuts from falling fruit-filled cans. She was taken to an emergency room of a nearby hospital for treatment but was told to leave and come back when she sobered up.

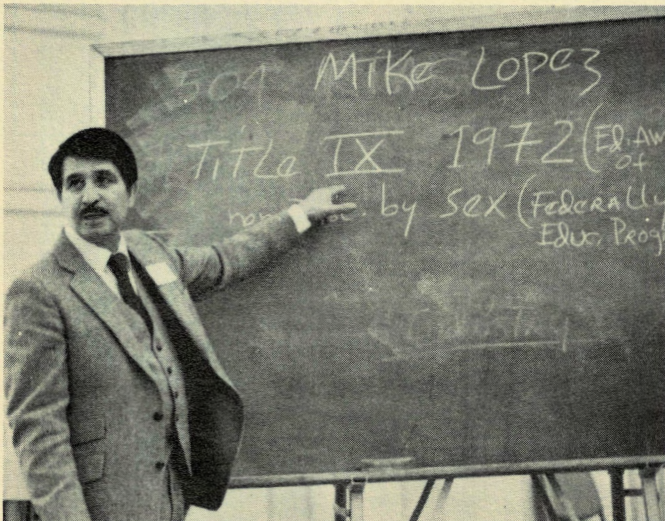
Questions asked concerning the case study were: was she discriminated against under Section 504? was Suzanne handicapped? what corrective action should be taken?

MESA informed the attendees that handicapped people with drug addiction and alcoholism cannot be discriminated against in either admission or treatment by hospitals or other treatment facilities. For example, if an alcoholic person has a broken leg, the hospital is not obligated to treat the person for alcoholism if it has no such program. However, treatment of the broken leg is required.

Several other case studies focused on developmental disabilities as a "qualified" handicap, including people who suffer from mental retardation, epilepsy, autism, cerebral palsy, spina bifida, blindness, hearing loss, and severe learning disabilities.

### Where to Find Help

According to Lopez and the MESA workshop facilitators, most programs have within them appeals procedures which allow a handicapped person to discuss his/her rights and problems with officials. These procedures allow a person to take their problems to officials of higher authority if there is no solution to the problem. The appeals procedure often includes a hearing.



MIKE LOPEZ from the U.S. Department of Education Regional Office in Denver discusses different laws that guarantee basic human and civil rights to the handicapped during a legislative review session at the MESA workshop in Denver February 19-20.

The hearing, continued Lopez, is an official way to present a problem to one or more "hearing officers" who act as judges. Lopez stresses that complaints concerning discrimination in programs and activities receiving federal funds should be directed to the regional office of the federal agency providing the funds. For instance, for programs aided by the Department of Health and Human Services, the regional DHHS Office of Civil Rights should be contacted.

According to Lopez, complaints must be acknowledged by the agency within 15 days and must be investigated within 90 days.

Civil rights and other protection agencies in states throughout the country can also provide counseling (individual and group), information about how to find other services, legal advocacy (speak for you in court) and systems advocacy (look at problems within program laws and policies and work toward changes to prevent future problems).

According to Carmelita Thomas, the MESA 504 workshops were designed to "give the handicapped back their dignity, self-sufficiency, and to help them get back into the mainstream of life." "We have to get the handicapped people out into the sunlight," said Thomas.

For more information concerning the Section 504 workshops — (which will be in Wolf Point, Montana - April 22-23; Ignacio, Colorado - May 7-8, and St. George, Utah - May 27-28) write MESA Corporation, Project 504; 1156 South State Street; Orem, Utah 84057 or phone: (801) 224-4674 (TTY or Voice) or Toll Free (voice or TTY) 800-453-1183. ■

### NIFNRC . . .

*Continued from Pg. 5*

According to NNSHP Project Coordinator Cathy Dailey, the project will build a model solar greenhouse, establish a seed bank, and provide expertise in agriculture training and technical assistance. "The Navajos will be depending more on the growing cycles and the sun rather than the unstable economy and government funding," said Dailey.

Included in the final day of the workshops was a presentation on Alaskan Subsistence Issues. According to Ralph Eluska, Fisheries Director for the Alaskan Native Foundation, many Alaska Natives are living in poverty, and to some extent their condition has been made worse by treaties, laws, and regulations that deny their right to subsistence hunting and fishing.

Eluska says the U.S. Government offers food programs to alleviate their poverty, but Alaska Natives want independence and self-sufficiency. "In Alaska, hunting the whale is as much our culture as it is a food source," said Eluska. "It is our right to live off the land. The Alaska Natives have been living off whales for 5,000 years and now it is in the process of being regulated."

A final urging by Kathleen McKee, attorney for the Food Research and Action Center in Washington, D.C. was made regarding the need to develop legislative priorities to improve Indian nutrition programs. "For the next three or four weeks, Indian people must continue to inform their congressman of the effect the cutbacks will have on their programs," said McKee.

According to NIFNRC staff, the symposium participants and NIFNRC will prepare a policy statement and fact sheet that will be presented to the Administration. ■



# Community-based Health Care Clinic Opens in Kayenta

KAYENTA, ARIZ.—A new health service clinic scheduled to open this month has been declared the first community-supported clinic located on an Indian reservation, according to Navajo Tribal Chairman Peter McDonald.

The Kayenta Community Health Service Clinic (KCHSC) will serve an estimated area population of 20,000, and will provide health care services to tourists and to non-Indians who work and live within the community, says Elwood Saganey, Navajo Tribal Councilman and the Chairman of the National Indian Health Board.

"There were many problems concerning the health care of our non-Indian residents," said Saganey. "Since Kayenta is so isolated, many of these people had to travel hundreds of miles to receive comprehensive health care."

According to Saganey and MacDonald, the community has been most generous in its support of the clinic. Peabody Coal and other businesses associated with the Navajo Nation have made significant donations to the clinic. Kayenta citizens organized several fund raising activities, including cake-walks, raffles, movies, taco suppers, and compiled a Kayenta community cookbook, said Saganey.

The clinic will be staffed by a National Health Service Corps doctor and dentist and will provide basic medical and dental services.

Dr. Melinda Payne, the clinic's medical doctor, says the facility will operate on a sliding-scale, fee-for-service and appointment basis and will depend on third party payments and continued community support for operating funds.

"Besides offering an alternative health care facility for our Indian population, we will also offer primary outpatient services, medical and dental care, general family practice

services, pediatrics, well-baby care, prenatal and obstetrical care, and basic orthopedic care to our non-Indian residents," said Dr. Payne.

Payne also stated that the clinic will seek to work with the community medicine men and hopes to utilize traditional Navajo healing practices whenever applicable.

According to MacDonald, "a community controlled and supported clinic is a step toward self-sufficiency in determining the type of medical care available to all residents of the Navajo Nation."

"Now people can get their diabetes shots locally or have their teeth cleaned without driving to Flagstaff or Page, and the passing tourist suffering from heat stroke after climbing a trail on a hot summer's afternoon will be treated immediately," said MacDonald. ■

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