



NIHB Health Reporter

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President Carter Signs Mental Health Systems Act

WASHINGTON, D.C.—For many years, the treatment of mental health disorders among American Indians and Alaska Natives has been severely limited. Isolated living conditions of Indian reservations and Alaska villages, populations too small to qualify as federal "catchment" areas, and inadequate funding for Indian Health Service (IHS) mental health programs are only a few factors that have contributed to the lack of much-needed mental health services to Native Americans.

A major step toward correcting this past neglect and improving mental health care treatment for Indian people was taken with the passage of the Mental Health Systems Act (P.L. 96-398), which President Jimmy Carter signed into law here October 7. Carter stated that the law, which authorizes the expenditure of nearly \$796 million through fiscal year 1984 for the startup of mental health programs, "will help those most in need, most underserved in the past."

One of the major purposes of the new law is to increase mental health services to populations that have been underserved in the past, including the chronically mentally ill, young people, the elderly, racial and ethnic minorities, and those persons living in rural areas.

Among those populations not adequately served by earlier mental health legislation are American Indians and Alaska Natives, according to Lindsley Williams, director of the Office of Program Development and Analysis for the National Institute of Mental Health (NIMH).

As explained by Williams, in order to previously qualify for NIMH grants, agencies were required to provide a full range of comprehensive mental health services to large populations, or "catchment" areas. Because of the remoteness of many reservations, the relatively small size of tribal populations, and the difficulty in establishing such a

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PRESIDENT JIMMY CARTER signed the Mental Health Systems Act (P.L. 96-398) October 7, a measure which authorizes almost \$800 million for mental health services through fiscal year 1984. Under the new law, Indian tribes and organizations will be able to apply directly for grants to provide certain mental health services to Indian people. Attending the signing ceremony were: Rosalynn Carter, honorary chairman of the President's Commission on Mental Health; Senator Edward Kennedy (D-Mass.), Chairman of the Senate Subcommittee on Health and Scientific Research; Patricia Harris, Secretary of Health and Human Services; and Representative Henry Waxman (D-Calif.), Chairman of the House Subcommittee on Health and the Environment.

(Photo by Jack Kightlinger, White House Photo Services)

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complete array of services, Indian people were rarely able to participate in NIMH-sponsored mental health programs.

With the passage of the Mental Health Systems Act, several important changes have been made in the funding process that will provide tribes and Indian organizations with a much greater opportunity to be involved in — and even manage — mental health programs for Indian people.

First, funding will no longer be limited to just those organizations capable of providing complete mental health care treatment. Eligibility for NIMH grants will be expanded to allow certain entities — including tribes, intertribal organizations, and urban Indian organizations — to offer limited mental health services, such as outpatient counseling, screening, consultation and education. Agencies contracting for these limited services can then build up their programs over a period of time.

Secondly — and equally as important — is a provision allowing tribes, intertribal organizations, and urban-Indian organizations to apply directly to the Secretary of Health and Human Services (HHS) for grants to deliver mental health services to American Indian and Alaska Native populations.

As stipulated under section 308 of the law, applications made directly to the Secretary must be certified by IHS as

being consistent with the Tribal Specific Health Plan (TSHP) of the tribe or tribes served by the grant. Tribes and Indian organizations also have the option under this process to administer their own mental health programs, or they may request that IHS provide the services.

In making such applications directly to the Secretary, tribes and Indian organizations can bypass the process that requires a designated state mental health authority to review and rank all other grant applications within the state. Additionally, the Secretary may award grants for mental health services to tribes and Indian organizations without regard to other mental health agencies in the state.

The law's provisions for tribes, intertribal organizations, and urban Indian organizations, stated Williams, "are fully compatible with Indian Self-Determination and recognize the sovereign status of tribes" in the funding process.

According to IHS Director Dr. Emery Johnson, "the Mental Health Systems Act is a major breakthrough for tribes because it permits tribal governments to apply directly to the federal government for support of their mental health programs." Johnson said he is also optimistic about NIMH's commitment to assist tribes and Indian organizations in improving mental health services to Indian people.

NIHB General Counsel Daniel Press, who worked extensively with IHS and NIMH officials on the Indian

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NIHB ZBB Training Sessions Begin in Albuquerque

ALBUQUERQUE, N.M.—The National Indian Health Board (NIHB) kicked off the first of twelve "Zero Base Budgeting" (ZBB) training sessions here October 15-16, with approximately 35 tribal leaders and Indian health administrators in attendance.

The training session, conducted by NIHB Health Planner Sandi Golden, provided participants with the technical information needed to allow tribes to become directly involved in the IHS budget process. The two-day training also included materials and a training manual that has been developed over the past several months by NIHB staff. In addition to information on Zero Base Budgeting, the manual provided participants with an orientation to the IHS cost accounting system that will be partially implemented by FY 1981. This accounting system is designed to more accurately identify the costs of all operations of IHS. IHS officials project that the new system will improve IHS management capabilities.

The Albuquerque training session included an examination of various aspects of the ZBB process, which requires the analysis of all programs and activities (their purpose, cost, and benefits) as opposed to traditional (or incremental budgeting, which requires incremental cost changes from the previous fiscal year.

According to NIHB Executive Director Jake Whitecrow, the purpose and focus of the ZBB training is to bring about an awareness of the budget process that would enhance better working relationships between tribes and their respective IHS service units area offices. The process has been designed so that tribes can work closely with IHS at each level of the budget development, he said.

IHS Director Dr. Emery Johnson has stated on several occasions that this kind of involvement by tribes is a logical outgrowth of the Tribal Specific Health Planning (TSHP)

process, which was initiated three years ago to give tribes the opportunity to plan their own health care programs and identify the resources needed for those programs. More than 280 tribes completed TSHP's for the *IHS National Plan for Fiscal Years 1981-1984*, which was mandated by P.L. 94-437, the Indian Health Care Improvement Act. Johnson has also stated that much of the data in the TSHP's could be utilized by tribes in the budget development process.

Whitecrow told workshop attendees that total tribal participation in the IHS budget development process is necessary for the system to succeed. "If Indian people are to have a truly active voice in improving the quality of their health care services, there must be a greater commitment to health management and administration, with an eventual goal of having tribes and Indian organizations actually providing the health care services budget, as proposed by the National Indian Health Board, is essential to Indian people achieving this goal," he said.

According to Golden, future ZBB training sessions have been scheduled for:

- October 20-23 in the (Eastern) Oklahoma Area in Sulphur, Okla.
- November 12-14 in the Navajo Area, Window Rock, Ariz.
- November 13-14 in the Sacramento Area.
- November 17-18 in the (Western) Oklahoma Area.
- November 18-19 in the Aberdeen Area.
- November 20-21 in the Tucson Area.
- November 24-25 in the Bemidji Area, Duluth, Minn.
- December 2-3 in the USET Area, Nashville, Tenn.

For further information on these training sessions, contact: Sandi Golden, Health Planner; National Indian Health Board; 1601 Parker Rd., Suite 200, Denver, Colo. 80231. Phone: (303) 752-0931.■

Health News Across the Nation

The following is a regular feature in the NIH Health Reporter. In this section, we present readers with short, concise briefs on issues and activities 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 in these short reports can be obtained from the NIH Public Information Office.

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WASHINGTON, D.C.—The 96th Congress recessed October 2, and will reconvene November 12 following the November elections for a "lame duck" session. Among the many legislative items to be reviewed during this session are: (1) extension of the Indian Health Care Improvement Act (H.R. 6629; S. 2728) from FY 1981-FY 1984. The House and Senate have passed different versions of the bill, which awaits conference action; (2) IHS appropriations for FY 1981; and (3) extension of the Senate Select Committee on Indian Affairs (S. Res. 448).

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WASHINGTON, D.C.—President Jimmy Carter signed H.J. Res. 610, the Continuing Resolution for FY 1980, here October 1. The Resolution was needed to continue operations of the federal government in lieu of various appropriations bills, which Congress will consider when it reconvenes November 12. The Continuing Resolution provides that FY 1981 for government operations — including Indian Health Service — appropriations will continue at the rate provided in the House version of the appropriations bills, or at the FY 1980 rate, whichever is lower. The resolution provides for funding authority through December 15, 1980.

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WASHINGTON, D.C.—Sen. John Melcher (D-Mont.), chairman of the Senate Select Committee on Indian Affairs, wrote a Dear Colleague letter to other members of the Senate expressing his sense of "urgency and concern" about the future of the Indian affairs committee. In the letter, dated September 22, Melcher notes that the committee will be terminated at the close of the 96th Congress "unless Senate Resolution 448, making the committee permanent, passes the Senate." Melcher contended that "the potential for careful and equitable consideration of Indian issues will be severely diminished" if the resolution is not adopted. The resolution must be taken up at the "lame duck" session that begins November 12, or the committee will automatically be terminated.

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DENVER, COLO.—The Western Center for Health Planning recently completed preparation of a document, "Integration of Health System Plans and Tribal Specific Health Plans," for the use of tribal health planning departments and health systems agencies. Copies of this publication can be obtained free of charge by contacting: Howard Bad Hand, Program Analyst; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.

WINDOW ROCK, ARIZ.—More than 100 Navajo families have filed suit for damages resulting from a large spill of radioactive waste in July, 1979. The suit was filed in two tribal courts in New Mexico and Arizona against the United Nuclear Corporation, which operates a uranium mill at Church Rock, N.M. Last year, a dam at the company's mill tailing pond broke and spilled 100 gallons of low-level radioactive waste into the bed of the Rio Puerco, carrying the radioactive materials some 90 miles downstream. The suit asserts that the Navajos have been unable to use the river for water or for grazing, and they have complained that many of their animals have died from drinking contaminated water and eating contaminated grass.

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KYLE, S.D.—The Oglala Sioux Tribe recently announced the opening of a new alcohol and drug abuse program for persons 14-20 years of age. Titled Project Phoenix, the facility will house up to 20 persons and will provide such services as individual and group counseling, inpatient and outpatient treatment, Alcoholics Anonymous, Alanon, and Alateen. The program will also offer referral services to the families of their clients as well as family oriented counseling. Facilities at the new project include a kitchen, laundry, recreation and television rooms, and separate male and female housing rooms.

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PHILADELPHIA, MISS.—The Mississippi Choctaw Tribe has initiated a Handicapped Children's Early Education Program which will provide a number of services for handicapped children from birth to eight years of age. The program will provide medical, psychological, social, educational, and counseling services to children who are: blind, deaf, physically handicapped, speech impaired, mentally retarded, emotionally disturbed, and those with specific learning disabilities.

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WASHINGTON, D.C.—Proposed regulations governing the operation of special education programs for handicapped children enrolled or eligible for enrollment in Bureau of Indian Affairs (BIA) schools were published September 29 in the *Federal Register*. The purpose of the regulations is to establish a single comprehensive set of standards for ensuring that all handicapped children enrolled in BIA operated schools are provided a free, appropriate public education in the least restrictive educational environment appropriate to their needs. For further information on the regulations, contact Charles Cordova; Bureau of Indian Affairs; 18th and C Streets, N.W.; Washington, D.C. 20240.

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FT. COLLINS, COLO.—Approximately 75 tape recordings examining different nutritional problems among Native Americans are still available to tribes, Indian organizations, and other interested individuals.

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Alaska, Northwest Tribal Witnesses Testify at Senate Oversight Hearing

PORTLAND, ORE.—Inadequate resources for P.L. 94-437 programs, the lack of much-needed contract health care funds, alcoholism, and the need for a stronger commitment by the federal government to tribal management of Indian health programs were among the major issues addressed by more than 30 witnesses in testimony before the Senate Select Committee on Indian Affairs here September 20.

The half-day hearing — the third and final session in a series of Senate field oversight hearings on the Indian Health Service (IHS) — was open to witnesses from the states of Oregon, Idaho, Washington, and Alaska. Previous Senate oversight hearings were held earlier this year in Phoenix, Ariz., and Billings, Mont.

One of the primary purposes of the Portland hearing, according to Sen. Mark Hatfield (R-Ore.), was to assess the effectiveness of the Indian Health Care Improvement Act (P.L. 94-437) in achieving the law's goal: to raise the health care status of American Indians and Alaska Natives to a level equal to that of other Americans. Hatfield told those attending the hearing that legislation to amend and extend P.L. 94-437 through FY 1984 has passed both the Senate and House, and awaits conference committee action.

Addressing a concern identified by a majority of the witnesses, Virgil Gunn, of the Confederated Tribes of Colville Indians, told the Committee that implementation of P.L. 94-437 programs has been impeded because of inadequate resources. He called on the committee to "help correct the Administration's timid approach to funding for Indian health care."

Gunn specifically cited the need for additional funding for tribal alcohol programs. Although "alcoholism is the number one disease and killer on our reservation," he stated,

funding remains far below what is needed to operate effective alcohol programs.

Similar problems with inadequate resources for alcoholism treatment exist in the Swinomish Tribal Community, where more than 60 percent of all hospitalization is alcohol-related, according to Swinomish Community Health Representative Barbara James. Lack of funding hinders not only the treatment of alcoholism in the Swinomish community, but prevents tribal members from receiving eyeglasses, hearing aids, and other medical services, James testified.

She also criticized federal regulations requiring tribes to seek alternative resources for health care. Such provisions often force Indian people to seek health services from state welfare agencies and other government entities, which James contends is a violation of the federal government's trust responsibility to Indian tribes. "Indian health care is not a welfare program," she charged. "It is a right Native Americans are entitled to."

Testifying on this same issue, Northwest Portland Area Indian Health Board (NPAIHB) member Constance Waters asked the Senate Select Committee to initiate efforts to repeal provisions related to the alternative resources requirement. Waters stressed that Indian people should be provided with a defined level of services, and she urged the committee to consider a guaranteed health care benefit package for Indians as an approach to providing these services.

The NPAIHB testimony also criticized the recent \$2.2 million cut made by the House Appropriations Committee in the IHS tribal management program for FY 1981. Waters

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SENATOR MARK HATFIELD (R-Ore.), right, chats with two gentlemen from Alaska following completion of Senate Committee hearing. Pictured with Senator Hatfield are Robert Clark (left) of the Bristol Bay Health Corporation (left) and Niles Cesar (middle), director of the Southeast Region Health Corporation.

stated that such a cut will severely hinder tribes' ability to deliver adequate health services on reservations.

Voicing similar sentiments, Quinalt Tribal Chairman Joe de la Cruz noted that tribal management capabilities in the field of health have evolved significantly in recent years. But, he said, "tribes are being asked to manage with fewer funds, and at the same time inflation is eating away at the value of the dollar. The result is a drastic reduction in resources for tribal management, while the responsibilities of tribal management continue to grow."

Tribal management of health care programs — and issues related to contracting for the delivery of health services — was the major focus of testimony presented by witnesses from the state of Alaska.

Representing the Bristol Bay Area Health Corporation in Dillingham, Alaska, Robert Clark told the committee of his organization's efforts to become the first tribal entity in the United States to completely operate all IHS services to its community. The Bristol Bay Corporation is comprised of 32 villages in a 40,000 square mile area, Clark explained.

Although the corporation was to take control of health programs October 1, Clark told the committee that "it is very little to the credit of the Indian Health Service that this will happen, since the Alaska Area Native Health Service has put every conceivable roadblock in our people's path of self-determination."

"Since P.L. 93-638 was passed," he continued, "we have had to fight for every scrap of information that allowed us to implement its principles, and then we had to fight again just to be allowed to contract with the government to serve our people."

Clark bitterly denounced federal regulations pertaining to tribal self-determination in the area of health care management and asked the committee to consider making "drastic changes" in the government's P.L. 93-639 policies.

Paul Sherry, director of the Tanana Chiefs Health Advisory Board, also testified on the need for greater tribal involvement in health programs, particularly in the area of budget development. In order for the Administration's Zero Base Budgeting system to work effectively, Sherry stated, tribal groups must be given an opportunity to meaningfully participate in the process.

Additionally, Sherry told the Committee that his organization — which provides health services to Athabaskan Indians and hopes to operate a comprehensive health program by 1985 — has experienced numerous problems acquiring resolutions of support from villages it serves. Such resolutions are necessary for an organization to contract under P.L. 93-638 authority.

This problem is a serious handicap to all 12 Alaska regional health corporations, according to Niles Cesar, executive director of the Southeast Regional Health Corporation. His corporation serves 19 villages that are spread throughout a vast area in Southeast Alaska, and travel to each of these villages for resolutions of support is prohibitively expensive, Cesar said. When resolutions cannot be obtained from one or two villages, he continued, the entire health program for the area is adversely affected.

Much of the problem rests with "federal regulations that are developed and implemented nationally, without regard to the unique problems of different geographical areas. IHS needs to define regulations that take these kinds of factors into consideration," Cesar stated. He asked the committee to



TESTIFYING ON BEHALF of the Northwest Portland Area Indian Health Board (NPAIHB) at Senate oversight hearing on the Indian Health Service was board member Constance Waters (right) and executive director Felicia Hodge (left). Among other things, the NPAIHB testimony requested the Senate Select Committee to consider a guaranteed health care benefit package approach to the delivery of health care services to Indian people.

attempt to eliminate unnecessary restrictions on tribal management and promote more creativity in the administration of tribal health programs.

In other issues addressed by witnesses at the Portland hearing, the Senate Select Committee heard testimony:

- from the Norton Sound Corporation in Alaska recommending: the establishment of a monitoring process for P.L. 93-638 contracts; an investigation into salary differences of IHS and tribal health personnel; and a change in the distribution of IHS funds to allow for more even spending over an entire fiscal year
- citing the need for a disaster relief program and increased funding for alcoholism treatment for the Mahkah Tribe
- requesting assistance in the construction of new health facilities serving the Nez Perce Tribe, the Shoshone-Bannock Tribe, the Warm Springs Tribe, the Colville Tribe, the Nisqually Tribe, and the Quileute Tribe
- requesting additional funding and authority for long range health planning, and a stronger commitment to the Tribal Specific Health Planning process
- recommending changes that would expedite the IHS cost-reimbursement process
- citing the need for water and sewage facilities in Sitka, Alaska
- requesting expanded funding authority for urban Indian health programs under Title V of P.L. 94-437
- requesting an amendment to P.L. 94-437 to expand emergency medical services on reservations.

Transcripts of the Portland hearing will be published within the next few months. Persons interested in obtaining copies may do so by contacting the Senate Select Committee on Indian Affairs; 6313 Dirksen Senate Office Building; Washington, D.C. 20510.■

Notes From the Executive Director:

Organizations such as the National Indian Health Board, the National Congress of American Indians, the National Tribal Chairmen's Association, the American Indian Health Care Association, and many others of equal importance around the country exist to address specific needs of American Indians and Alaska Natives.

Some of these organizations require individual dues-paying membership; some require the members to meet certain conditions; and others have no dues and have a select Board of Directors. They all seek funds with which to operate. Some are totally funded by the many agencies of the Federal Government. Some receive state funds with which to operate, while others try to meet the needs of their constituents by membership alone, or grants from foundations. Some organizations are designed to provide the many federal agencies and their administrators with information that would allow them to effectively change their delivery processes and improve services to our First Americans.

The National Indian Health Board has so many responsibilities that it is difficult to stay on top of them all. For instance, even though there are other organizations with responsibilities for a specific area in the field of health, NIHB has responsibilities to speak to all health issues affecting American Indians and Alaska Natives. We have responsibilities in the fields of Aging, Youth, Health Education, Nutrition, Health Manpower, Emergency Medical Services, Planning, Administration, Management, Alcoholism, Drug Abuse, Research, Preventative Health, Traditional Medicine, and every other situation that you can think of related to the health fields.

How do we do this? One way is that we respond to problems as they are brought to our attention. You can bring problems to the attention of your tribal leaders or boards of directors of your health clinics and service units. These problems are then considered at the local level, where boards of directors, health administrators, and tribal councils spend many hours in trying to resolve them.

Often, their solution requires that they bring these concerns to their area Indian health boards' attention, where they are considered with the Indian Health Service Area Directors and their staffs. Strong attempts are made to handle the problem at this level. When it is determined that further action is needed — and the solution requires a national focus — the area NIHB representative brings that situation to the attention of this Board.

It is at this level that a national resolution is often adopted to address the problem and presented to the agency that has the authority to do something about it. Sometimes these agencies can respond to the problem, while at other times they refer us to their next higher authority. We then have to go through the process again and again until, ultimately, we must provide our Congressional representatives with the problem. Occasionally, we then get some action.

NIHB has been making a sustained effort to get all other organizations to join us in the above endeavors. If all organizations would adopt supporting resolutions and process them in accordance with their own established policy, we would all be stronger. And if all Tribes would adopt the same resolutions supporting these efforts, it would just make us all that much stronger.

NATIONAL INDIAN HEALTH BOARD

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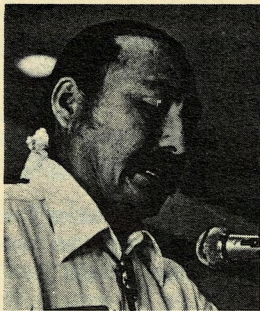
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Shortly, several of these national organizations are going to be conducting their annual or national conferences, and there will be hundreds of Indians in attendance. Resolutions are going to be presented at these meetings, and attendees will listen to the readings and raise their hands in support of or against those resolutions. Many will be adopted and the staffs of those organizations will be expected to "carry the ball" all by themselves.

Most of us will go back home and tell the folks that we did a good job: "We sure passed a lot of time and boy, was it hard to sit through all of that." Then, most of us forget it. That is until next year, when we go through the entire process again and, mostly, listen to the same problems and pass the same resolutions again. It seems that we fight the same problem, over and over. When will we learn that it takes follow-up by everyone to resolve an issue?

The staffs of NIHB and other organizations are doing a lot of work on these kinds of issues but we are not enough. We need every one of you to take action. We have lots of resolutions that we need help with. If you will write to us, we will send you copies of them. We need both Indian and non-Indian organizations and people to help us. The time has come to seek help from everybody. We Indian people have been trying to do it alone. I firmly believe that the American people — and we Indians and Alaska Native people included — want these problems resolved so we can get about

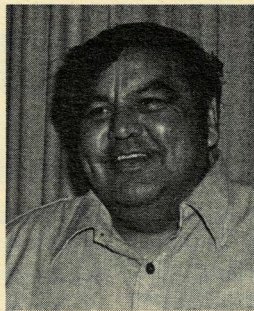
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Elwood Saganey
NIHB Chairman



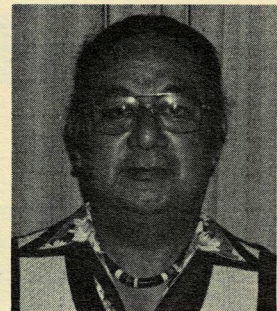
Lawrence Snake
NIHB Vice-Chairman



Donald LaPointe
NIHB Secretary



Billy Kane
NIHB Treasurer



Timm Williams
NIHB Member-at-Large

Saganey elected as chairman

NIHB Selects New Executive Committee

ANCHORAGE, ALASKA—The National Indian Health Board (NIHB) elected five new officers to its Executive Committee during the board's regular quarterly meeting here October 20-22.

The new committee replaces the previous three-member executive committee that was comprised of Howard Tommie, USET area representative, as Chairman; Timm Williams, California area representative, Vice-Chairman; and Ethel Lund, Alaska area representative, Secretary/Treasurer. Tommie, former chairman of the Seminole tribe of Florida, steps down after serving as NIHB's chairman for nearly five years, during which time he contributed significantly to the growth and stability of the organization.

NIHB's new executive officers are: Elwood Saganey, Navajo area representative, Chairman; Lawrence Snake, Oklahoma City area representative, Vice-Chairman; Donald LaPointe, Bemidji area representative, Secretary; Billy Kane, Phoenix area representative, Treasurer; and Timm Williams, California area representative, Member-at-large.

As NIHB's new chairman, Saganey said he hopes to help the organization "find some new directions, and try some new ideas, that will help promote better health care for Indian people across the country." Saganey has served as the Navajo representative to NIHB since 1972. He has been very active in health-related activities for the Navajo tribe, particularly in the area of alcoholism. Saganey has served on the Navajo Tribal Council since 1971, and is chairman of the council's Health, Alcoholism, and Welfare Committee, as well as the Navajo Area Indian Health Board.

Although he has been with NIHB for only two years, NIHB Vice Chairman Snake has established himself as one of the board's most active and distinguished members. A retired civil servant, Snake now serves as Chairman of the Delaware Tribe of Western Oklahoma and is chairman of the

35-member Oklahoma City Area Indian Health Board. Snake also sits on the board of directors of the White Cloud Center, a national institute involved in researching mental health problems among Native Americans, and serves as secretary for the National Tribal Chairmen's Fund.

With respect to future NIHB activities, Snake said he would like to see the board "get more involved in securing federal legislation pertaining to Indian health care." He said he also hopes the board can help establish a surveillance process for quality control of IHS hospitals.

NIHB Secretary LaPointe has been with the board since 1973, and has previously held positions as Vice-Chairman and Secretary/Treasurer. As longtime chairman of the NIHB Resolutions Committee, LaPointe has been actively involved in NIHB's attempts to address problems pertaining to Indian health care. He has worked in the field of health since 1962, and is particularly interested in the areas of mental health and mental retardation.

LaPointe is also active in Indian education, and is a board member of the Coalition of Indian Controlled School Boards; chairman of the Michigan Intertribal Education Association; and director of the American Indian Program at Michigan Technological University.

Although relatively new to NIHB, Billy Kane, the board's new treasurer, has worked in Indian health activities since 1968. He chairs the White Mountain Apache Health, Education, and Welfare Committee as well as the Phoenix Area Indian Health Board, and is treasurer of the Phoenix Area Intertribal School Board. Kane — who has worked with the White Mountain Apache Tribe for 23 years — is also chairman of the tribe's Radio Broadcasting Committee, and has been instrumental in efforts to establish a radio station on the reservation.

The final member of the NIHB Executive Committee, Timm Williams, is one of the original founders of the organization. One of the board's more vocal members, Williams has twice served as NIHB Vice Chairman. He is chairman of the California Rural Indian Health Board (CRIHB), a position he has held for the past four years. Williams has been deeply involved in Indian issues on local, state, and national levels for the past 25 years, and in 1972 was recognized as "Man of the Year" by the National Academy of Pediatrics for his many accomplishments in the area of Indian health care.

The NIHB Executive Committee will hold its first meeting in San Diego November 13. It is expected that the committee will take an active role in directing the operation of NIHB. ■

Notes . . .

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performing our other tasks of improving our Nations. I have not talked to very many non-Indians that are against Native American rights after I take the time to explain the American Indian-U.S. Congress legal relationships to them. Have you? If so, send us their names and addresses and we will send them some information.

See you at one of the Conferences. Be sure and vote in the national and local elections — your participation in the electoral process is important. I also hope you were counted in the recent Census. Were you?

j.w.

Indian Aging Conference and Socio-Economic

ALBUQUERQUE, N.M.—In an effort to examine the current economic, social, psychological and political status of the Indian elderly and to gather an effective consensus that could impact national policy, the Third National Indian Conference on Aging was held here September 8-10.

Recent surveys have indicated that the health and economic status of the Indian elderly has risen, but this unique population is still plagued with limited employment opportunities, lower life expectancies than that of the general population, geographic isolation, and service disparities.

Added to these situations are the sociological changes occurring on and off the reservations. The spirit of generational sharing that once was so strong in the Indian family may be weakening due to many of the younger generation leaving the reservations and Indian communities for employment in the cities.

The conference, a regular biennial event of the National Indian Council on Aging (NICOA), addressed many of the Indian elderly's needs and sentiments as well as creating a forum for the 1,500 conferees who were called upon to play an active part in developing national policy for the Indian elderly. The conference was held in preparation for the National White House Conference on Aging, which is scheduled for late November or early December, 1981. The purpose of the White House conference is to draft a national aging policy agenda to guide legislative and administrative actions for the next ten years, with approximately 1800 delegates expected to represent the American elderly.

According to NICOA's Executive Director Alfred Elgin, "We hope our conference on Indian aging will become the foundation for the national Indian aging policy, direction

and philosophy for the next ten years." Elgin says the conference results would be used to develop programs that genuinely reflected the uniqueness of elderly Indians.

By combining grassroots input from American Indian and Alaska Native elderly with that of service providers that attended the conference, NICOA states that they hope to develop a coordinated approach to effective and adequate services for the Indian elderly. The organization also plans to use the findings in the development of resolutions, strategies and a position paper that would be presented (through delegates to be selected and trained) at the White House conference.

Conference speaker Becky Washington, a White House Conference on Aging staff person, told conferees that it is of the utmost importance to provide a substantial number of Native American delegates to the White House conference, and she encouraged the Indian elderly to become active in their state and regional aging conferences.

In addition to this immediate goal, other specific objectives of the Indian elderly conference, according to NICOA, were: (1) to provide a forum for Indian and Alaska Native communities nationwide, identify unmet needs, and develop recommendations for remedial action; (2) to disseminate accurate and current information on the provision of services under the Older Americans Act and other federal programs as they relate to American Indian concerns and needs; (3) present overviews of barriers inhibiting effective utilization and coordination of resources; (4) to formulate action leading to improved comprehensive services for the Indian elderly, and (5) to promote national sensitivity to the needs of the Indian elderly.



TWO HOPI WOMEN take a moment to chat during the Third National Indian Conference on Aging in Albuquerque September 8-10. More than 145 tribes were represented among the estimated 1,500 participants at the conference.

Examines Health, Political, Status of Indian Elderly

The conference, supported in part by grants from the Administration for Native Americans, Bureau of Indian Affairs (BIA), Indian Health Service (IHS), ACTION, and the Administration on Aging (AOA), drew participants from more than 145 tribes.

Opening the conference was a keynote address delivered by Ron D. Wood, Director of the Division of Health Improvement Services for the Navajo Nation. Wood reviewed the progress made by the Navajo Tribe in the area of aging programs and in the promotion of legislation for the Indian elderly. He also stressed the responsibility of tribes and Indian organizations to advocate for Indian aging programs that meet cultural needs and preserve the Indian way of life.

Banquet speaker Overton James, Chief of the Chickasaw Nation, addressed the generation gap and the deterioration of the extended Indian family. "The young have grown apart from the elders, and need to be educated to understand the old ways and old values," James said. "These old values include keeping the elderly within the family structure and not putting them away in nursing homes. They should be a valued part of the family."

The heart of the conference was the schedule of 26 workshops presented in panel style, with a workshop moderator guiding the presentations and discussions. Each workshop was expected to present recommendations and resolutions on the last day of the conference.

Workshop topics included pertinent issues such as: institutional care, in-home services for the elderly, transportation, nutrition, pensions, energy, youth and the elderly, research and development, political activism, the future, tribal energy development. Several of the workshops also included subjects relating to health, particularly in the areas of bio-medical research, institutional care for the elderly and future institutional care.

Bio-Medical Research Workshop

Bio-Medical Research Workshop panel member Dr. Calvin Lang from the University of Louisville, Kentucky, addressed the question of Indian alcohol susceptibility and whether there is any biological basis for it. Lang said an extensive research study should be made to determine if there is anything specific in the Indian biological makeup that could demonstrate unusual susceptibility to alcohol.

Dr. K. A. Jaggannathan from the Administration on Aging (AOA) discussed the importance of research in areas of social and economic impacts upon the Indian elderly. According to Jaggannathan, the social and economic factors may possibly account for anxiety, depression and the high level of unemployment experienced by the older and younger American Indians.

Nutrition was also discussed, especially in the area of protein and how it affects the Indian elderly. Dr. Lang said that research is being done on the Indian population in areas of what they eat, what effects fat and carbohydrates have on the population, and the importance of calcium for elderly women in menopause.

Institutional Care and the Elderly

Pertinent topics presented and discussed at the Institutional Care and Elderly workshop were in the areas of communities and nursing homes, death by choice, advocacy, education, and elderly home and/or institutional care.

Panel moderator Jake Whitecrow, executive director of the National Indian Health Board (NIHB), said that concerns of the workshop and the National Indian Conference on Aging would be brought to the attention of the 12-member National Indian Health Board. He also stated that NIHB would work to unify other national Indian organizations to bring about a unified effort and advocacy for the Indian elderly.

Panel member Steven Harden, an administrator for the Oneida Nursing Home in Oneida, Wisc., said there are many alternatives the elderly could take in deciding what type of housing, health care and nursing home would be best suited for them. Harden discussed an independent type of living situation for the elderly with some type of in-home service as one alternative, and cluster-type housing and maximum types of care provided by nursing homes as other examples of living and health care alternatives. Harden also stated that the Oneida Nursing Home preferred rehabilitation of the elderly, rather than "just putting them away in a home to die."

Panel member Michel Bird, a counselor for the Santa Fe Indian Health Service Hospital said that he believed Indian elders should speak up for what they want and need.

Bird, who counsels and refers Indian elderly to area nursing homes, said "systems like IHS, BIA and state governments respond to pressure if you are out there making noise. In many cases they will give you what you want." Bird also encouraged Indian elderly to be aggressive and not give up what they think is right. "I know this is often hard for Indian people to do, but alliances or councils made up of elders are valid and viable ways to put forth demands," Bird said.

Institutional Care for Tomorrow's Indian Elderly Workshop

The Institutional Care for Tomorrow's Indian Elderly Workshop's panel and audience discussed alternatives for care and housing of Indian elderly and the incorporation of Indian Medicine men and traditional medicine in an institution. Other topics discussed were the location of nursing homes near large Indian populations, nursing homes built with definite cultural traits specific to a particular tribe; and the possible allocation of space and beds for hospitalized elderly in IHS hospitals.

Panel member Maxine Chuculate, a representative of the American Indian/Alaska Native Nurses Association and a public health nurse for over 35 years, said that frequent evaluations of patients are needed for elderly that have been placed in nursing homes. Another point made by Chuculate was that the distance between nursing homes and the

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A CONFERENCE PARTICIPANT from Cherokee, N.C., questions federal representatives at the "Administration on Aging and Title VI" workshop. Title VI of the Older Americans Act, as amended in 1978, allows tribes to apply directly to the Administration on Aging (AOA) for funds to provide nutrition services to elders age 60 and over.

Indian Aging . . .

Continued from Pg. 9

family of the elder should be as short as possible. She also stressed the need for an intermediary that would prevent an elderly person from being put into a nursing home without a justifiable cause.

During the final day of the conference, attendees developed the following resolutions:

- a need for all IHS service units and urban Indian health programs to seek consultation and work with spiritual leaders of the patients' choice whenever possible
- a need for information about services and resources to be provided to the elderly
- a need for a coordinated transportation system to be established to provide mobile health screening and care for the elderly
- a need for interpreters to be provided at IHS facilities and meetings
- a need for tribal governments to assume a closer control and responsibility over health and social research projects and a need for tribal governments to control the initiation of research to insure the protection of human subjects
- a need for Native foods to be included in federal nutrition packages and a need to explore a ways and means for a National Indian food distribution process
- a need for a revision of eligibility rates for Indian elderly for an easier participation in the USDA Food Distribution Program
- a need for existing elderly homes to be improved with an emphasis on energy saving techniques.

According to NICOA, proceedings of the conference will be available to the public sometime in late November. For information on receiving a copy of the proceedings, contact: The National Indian Council On Aging; P.O. Box 2088; Albuquerque, N.M. 87103. Phone: (505) 766-2276.■

Health News . . .

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The recordings, or "radio plays", are based on recommendations and comments of participants at two Native American nutrition conferences: a regional conference held in Flagstaff, Ariz., January 14-16, and a national conference in Colorado Springs March 24-26. The conferences were jointly sponsored by the National Indian Health Board and Colorado State University. The tape recordings discuss specific issues and policy alternatives related to Native American Nutrition and Diabetes, Nutrition and the Elderly, Nutrition and the Family, Nutrition and Alcohol Abuse and Scientist/Indian Relationships.

For further information on the health issues series, or to request the recordings, contact Dr. Alan Ackerman; Department of Food Science; Colorado State University; Ft. Collins, Colo. 80523.

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NIHB-CSU Science Center Funded by Donner Foundation

FT. COLLINS, COLO.—The Department of Food Science and Nutrition at Colorado State University has received a \$50,000 grant from the William H. Donner Foundation to establish a National Indian Health Board Public Service Science Center, according to university officials.

The center will deliver scientific expertise and disseminate information relating to nutrition and health to Indian communities nationwide as part of a continuing effort of cooperation and project development between the National Indian Health Board (NIHB) and Colorado State University (CSU).

The first phase of the center's operations will begin next month with joint policy decisions concerning the center's development made by NIHB and CSU, says Dr. Alan Ackerman, the new center's director.

"One of the important purposes of the center is to make scientific information available to people in local communities. The products of the center (audio visual materials in areas of diabetes, traditional food, and breast and infant feeding practices) can be used by people who have obtained various educational levels. The format of the center's work even permits use of audio visual education in reservation areas where no electricity is available," Ackerman said.

The priorities of the center for the next six months, says Ackerman, will center on breastfeeding and infant feeding practices, a model demonstration project in nutrition education for tribes, nutrition and diabetes, and traditional foods of American Indians.

"Some significant problems that have been cited are in the area of nutrition," said Ackerman. "We have found, for example, that the amount of breastfeeding among Native Americans has declined rapidly since the 1960's, which may be contributed to the increasing rate of tooth decay among infants," said Ackerman.

Phase two of the center's operation is due to begin in the Spring of 1981, and will involve providing scientists to tribes in 50 short-term projects in the areas of drug abuse, nutrition and occupational health. Funds for the second phase are still pending, says Ackerman.■

Proper Nutrition Seen as Essential in Reducing Incidence of Otitis Media

While otitis media is a disease that affects children of all populations, it is particularly prevalent among American Indians and Alaska Natives. According to some studies, the incidence of otitis media, or middle ear disease, may be as high as 50-60 percent among Native American children during the first two years of life.

Last year, in the October issue of the NIH Public Health Reporter, we featured an article written by Raymond H. Hull, Ph.D., Chairman, Department of Communication Disorders and Director of Audiology at the University of Northern Colorado, dealing with the problems associated with otitis media. As a followup to his original article, we are pleased to be able to present the following discussion by Dr. Hull on some of the causes of otitis media, its symptoms, and some measures that can be taken to help prevent the disease.

We invite our readers to comment on Dr. Hull's article. Responses can be sent to the NIH Public Information Office, or to Dr. Hull at the University of Northern Colorado; School of Special Education and Rehabilitation; Greeley, Colo. 80639.

Of the 3.3 million babies born in the United States in 1978, approximately three-fourths will have experienced middle ear disease (otitis media) at least once by the time they are two years old, according to Jerome O. Klein, M.D., Professor of Pediatrics, Boston University. Dr. Klein states further that at least 33 percent will have three or more episodes of otitis media during their first two years of life. Dr. Burton Jaffe of Harvard University Medical School and others report a much higher incidence of otitis media among Native Americans than among other populations. The incidence reported by some authorities reveal that otitis media among Native American children may be as high as 50-60 percent during the first two years of life.

Repeated bouts of middle ear disease in early childhood can result in damage to the inner ear structure, causing permanent damage to a child's hearing.

In addition to permanent damage to hearing, other significant effects on children have been found. One of critical importance, delayed language development, occurs when children experience middle ear disease on a repeated basis during the important language learning years of birth to three years. Since language is the basis for the development of speech and all learning including reading, vocabulary for talking, writing, arithmetic and others, acute hearing during the first three years after birth is critical.

Since otitis media frequently results in hearing loss of varying degrees, the child who has it is not afforded the opportunity to hear all that is necessary to develop strong language skills. If the decreased hearing persists during the first three years of a child's life, the results may be reflected through decreased ability to read, to use language through speech (express him or herself well), or learn other things that are necessary for school, future occupations, and social life. Marion Downs, Associate Professor of Otolaryngology at the University of Colorado School of Health Sciences, has shown predictable relationships between chronic otitis media with accompanying loss of hearing, even at mild levels, and disorders of language and learning.

Other dangers which frequently accompany chronic (repeated) otitis media include: (1) permanent damage to the

tympanic membrane (ear drum) due to repeated perforations; (2) cholesteatoma, a tumor made of skin resulting from perforations of the ear drum, which can erode into other areas of the bone housing the middle ear and can damage the inner ear causing permanent hearing loss; (3) mastoiditis, or invasion of active middle ear to cause permanent hearing loss (see diagram pg. 12). The infection from mastoiditis can also invade brain tissues. In advanced cases, death can occur.

What Is Otitis Media?

Otitis media is described as disease of the middle ear. The middle ear is the portion of the ear which transforms air movements so that sound can be transferred to the inner ear, to then be transmitted to the brain to be interpreted as sound. Any reduction in the middle ear's ability to receive and transmit sound vibrations results in a reduction of hearing. Thus, the child experiences a hearing loss.

A cold or other infection that causes swelling of the throat can close the eustachian tube opening. In cases where bacteria also reaches the middle ear, infection and resulting disease, swelling of the lining of the middle ear, and an accumulation of infected fluid can occur. A throbbing earache, fever and possible rupture of the ear drum can accompany otitis media.

Causes of Otitis Media

Eustachian Tube Malfunction

Otitis media that is chronic (of long duration or repeated) is generally associated with a eustachian tube that does not open properly. The eustachian tube is a narrow tube-like structure which interconnects the middle ear with the upper part of the throat. Its function is to regulate air pressure from the outside air to the middle ear. Such pressure regulation is important to maintain correct function of the ear drum, and for the middle ear to remain healthy.

For some children and adults, the opening of the eustachian tube does not function properly. The reason for this is not generally known, but it does appear to relate either to impairment of the muscles which control the opening of the eustachian tube, or lack of stiffness of the cartilage which supports the tube, which appears to be common in children under age ten.

Colds and Infection

Other causes of eustachian tube malfunction include colds or other infection that causes swelling of throat tissue close to the eustachian tube opening, including adenoid tissue. In cases where bacteria or viral disease also reach the middle ear, infection causing swelling of the lining of the middle ear and ear drum, and an accumulation of infected fluid can occur. The middle ear system, therefore, cannot transmit sound well, and hearing is reduced. If the disease persists, not only does the reduction in hearing continue, but also the possibility of permanent hearing damage and danger to the child's health.

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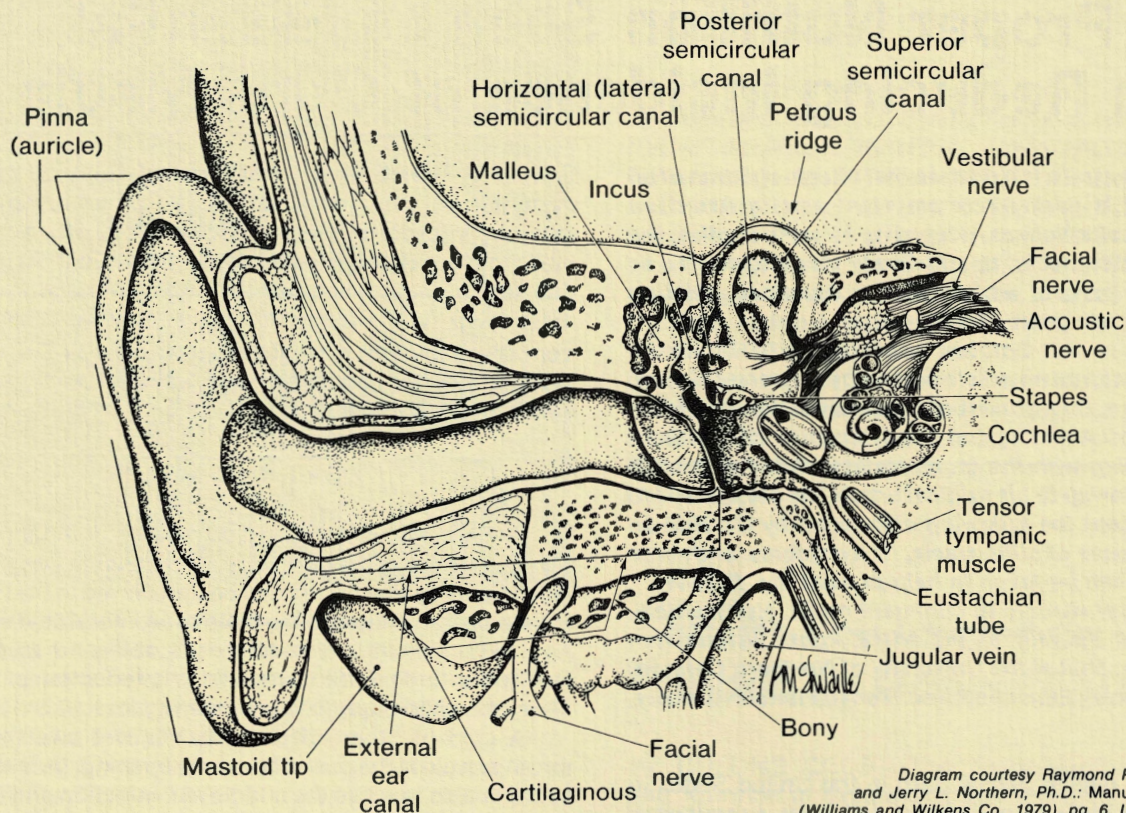


Diagram courtesy Raymond P. Wood II, M.D., and Jerry L. Northern, Ph.D.: *Manual of Otolaryngology* (Williams and Wilkins Co., 1979), pg. 6. Used with permission.

Proper . . .

Continued from Pg. 11

Malnutrition

There is a direct relationship between upper respiratory infection (colds) and middle ear disease. Further, according to Dr. David Lim, of the Ohio State University School of Medicine, upper respiratory infections, among other diseases, are directly related to states of malnutrition. With malnutrition, otherwise natural protection of the tissues of the throat and nose area is greatly reduced. These areas are therefore less able to protect themselves from bacteria or viral diseases which may attack them.

In other words, good nutrition for children is necessary to protect them as much as possible from upper respiratory infection which can lead to related middle ear disease. This includes a well balanced diet, particularly involving adequate levels of vitamins A, C, and protein.

Another finding which is important to mention here is the effect of malnutrition among pregnant women on the ability of their child to resist middle ear disease after birth. For example, increased consumption of foods which contain vitamins A, B, and D are necessary to provide for the development of a properly formed palate and other bones of the body. This is noted because researchers such as Dr. Burton Jaffe have found a more frequent incidence of cleft uvulae among Native American children. The bifid uvulae is considered a near cleft palate. Among Native American children with major cleft uvulae the incidence of middle ear disease is twice as high as among normal Native Americans.

Further, Dr. Jaffe has found that 18 percent of ear drums among newborn Native Americans are either partially or non-mobile. He has also found that two out of three young children with ear drums that cannot move properly at birth develop otitis media before age one. He suggests the cause as a correlation between predisposing condition among

children and premature birth or complications during the mother's pregnancy. It appears that the child's resistance to disease may be lowered as a result in a child who is less resistant to disease may be malnutrition within the mother during pregnancy.

Time of Year

According to Dr. Lim, numerous studies have revealed that the incidence of otitis media increases during certain months of the year. The months of December to January, and March and April yield higher rates of middle ear infection. The relationship appears to be that of a higher incidence of upper respiratory infection during those months. The lowest incidence is usually found during the months of July and August.

Prevention and Control of Otitis Media and Its Effects

Of the many causes of otitis media, some can be prevented. Others can be controlled so that the effects of the disease or loss of hearing during critical periods of language learning can be reduced. Some important areas are:

- (1) There is a direct relationship between the state of health of children and their resistance to disease. Their nutritional level is directly responsible for their state of health. Balanced meals and adequate rest is essential to the above. Among all populations of Americans, some form of malnutrition among children appears to exist. "Junk food" (candy bars, pop, and others) does not contribute to good nutrition and health.

- (2) There appears to be a direct correlation between the nutritional and health status of women during

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pregnancy and their child's resistance to disease during the first year of life after birth. It is critical that women who are pregnant, or are planning to become so, remain in a consistent state of good health by eating nutritious meals and acquiring adequate rest. See your doctor for advice regarding good foods for good health.

- (3) During all seasons of the year, but particularly during winter months, it is important to make sure that children are dressed appropriately for the weather, get plenty of restful sleep, and, again, are eating nutritious meals. Prevention or reduction of colds and other illnesses that can result in middle ear disease depends upon this. A healthy, well-nourished child may still become ill, but he or she will stand a better chance of overcoming it more quickly than those who are not.
- (4) If the disease process from which middle ear infection develops causes inflammation of the tissues of the middle ear and ear drum, extreme pain

can be felt. Fever will generally accompany the infection. The child may cry from the pain of the infection. In some instances, the ear drum will rupture and the child may then cease crying, and the fever may fall. *Do not* assume that your child is then well. The disease process is still present even though the overt symptoms are hidden. Continue any medication your doctor has prescribed for the child. *If your child has not seen a doctor, it is very important that he or she be seen by one.* Chronic otitis media is not a normal childhood disease, although too many children experience it. It can be extremely dangerous.

- (5) It is important that the child who has otitis media be kept indoors, and provided fluids, nutritious foods, and rest.
- (6) Once again, it is very important that a child who is experiencing middle ear infection see a doctor. Early recognition and medical treatment are necessary to prevent spread of the infection and other problems that the child may face as the result of the disorder.■

Indian Water, Sanitation Issues Examined at National Rural Center Conference

By Daniel Press
NIHB General Counsel

SILVER SPRING, MD.—The National Indian Health Board participated in a conference on rural water and sanitation issues here October 1-3. The conference was called by the National Rural Center at the request of the White House Rural Task Force, which is looking into problems in providing adequate water and sanitation services to rural communities.

At the request of NIHB, a special session of the conference was devoted to the water and sanitation problems faced by American Indians and Alaska Natives. Representatives from NIHB, the Intertribal Council of Arizona, and a number of tribes participated in this session along with representatives from Indian Health Service (IHS), the Environmental Protection Agency (EPA) and the Farmers' Home Administration.

The main focus of this session was on the problems Indian tribes face in obtaining adequate assistance from each of these agencies. EPA has a massive program to provide grant and loan funds for wastewater systems. However, under the existing legislation, applications must be submitted to the state which, in turn, sets priorities among the proposals and submits its priority package to EPA.

Not unexpectedly, many tribes feel that the states do not properly rank Indian proposals, resulting in much less EPA funding going to tribes than is deserved, given the serious sanitation needs on most reservations.

One resolution to come out of the group was on the need to work with EPA to get legislative changes allowing for an

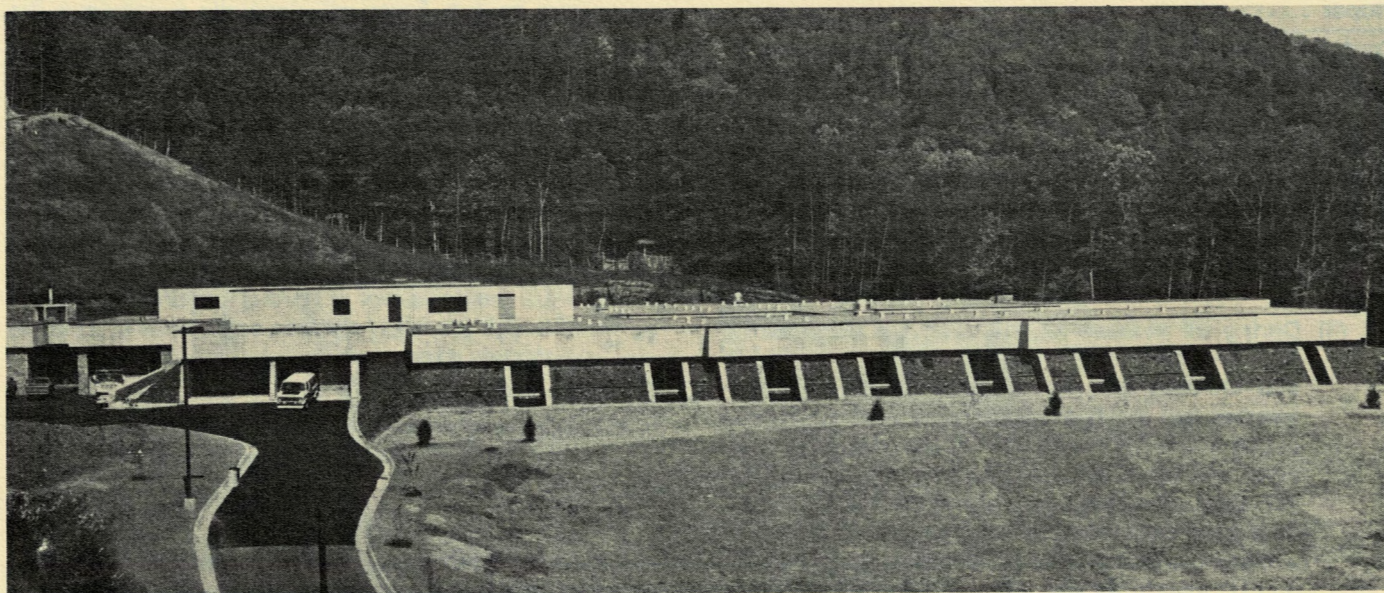
Indian set-aside and direct Indian applications to EPA in Washington. The EPA legislation is coming up for renewal shortly, and this issue will be pursued. Tribes which have had experiences with this problem are asked to submit information to NIHB that can be used in persuading the Administration that an Indian set-aside is needed in this legislation.

The second agency to be dealt with was the Farmers' Home Administration (FmHA). It has money both for water and sanitation systems and for housing, mostly on a loan but some on a grant basis as well. Representatives from FmHA said that with the work of Stuart Jamison, who heads the Indian Desk in FmHA, the agency is becoming more sensitive to the needs of Indians.

The FmHA Office in each state is now required to have an Indian Coordinator who is supposed to inform tribes and individual Indians of their opportunities under the FmHA program, and to assist them in preparing their applications. It was recommended by the conference group that FmHA join with IHS, the Department of Housing and Urban Development and the Bureau of Indian Affairs in the interagency agreement on Indian housing, since FmHA can bring extensive new resources to the Indian housing area.

One of the major focuses of the discussion was on the IHS water and sanitation program, particularly the need for increased operation and maintenance. Several years ago, the Office of General Counsel in HEW wrote an opinion stating that IHS could not spend money on ongoing operation and maintenance of sanitation facilities.

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THE NEW CHEROKEE Indian Hospital is located on the reservation of the Eastern Band of Cherokee Indians, in the heart of the North Carolina Smoky Mountains. The 35-bed hospital will provide the 8,800 reservation residents with a full range of comprehensive health services, including audiology, dental, environmental health, nutrition, pharmacy, physical therapy, general and specialized medical services, and many others.

Eastern Cherokees Celebrate Opening of New 35-Bed Hospital

CHEROKEE, N.C.—Nearly six years ago, members of the National Indian Health Board (NIHB) adopted a resolution calling for the construction of a much-needed new hospital for the Eastern Band of Cherokee Indians.

That resolution, which was subsequently adopted by participants at the First National Indian/Alaska Native Health Conference in 1976, was the first in a series of efforts by NIHB, the United South and Eastern Tribes (USET) Board, the Cherokee Tribal Council and the Cherokee Tribal Health Board aimed at replacing a small, outmoded reservation hospital that was constructed in 1937.

Those collective efforts were rewarded with the recent completion of an impressive new 35-bed Cherokee Indian Hospital, which was dedicated during tribal ceremonies here October 10.

Addressing more than 300 attendees at the dedication ceremonies, Cherokee Tribal Health Coordinator Jonathan Ed Taylor said that the new hospital "was the result of many years of effort by numerous committees, health boards, councils, and different tribal administrations." Taylor was instrumental in the initial study evaluating tribal health needs that strongly recommended a new hospital for the reservation.

Following that study, the tribe received a \$5,000 grant for planning the design and location of the hospital. The tribe encountered difficulties obtaining additional monies for the hospital, and extensive negotiations were needed between tribal leaders and federal officials before Congress appropriated funding for the hospital's construction as a specific line-item in the Indian Health Service (IHS) budget.

One of the principal tribal leaders involved in this funding process, Tribal Chief John Crowe, stated in his dedication letter to tribal members that "today we dedicate this hospital to the spirit of our people; those who worked before us, those who worked with us, and those children who

will someday work after us. The dedication is to filling the need of a proud people, and to their future."

Serving as keynote speaker at the dedication, IHS Director Dr. Emery Johnson praised the members of the Cherokee community "for their efforts and perseverance in getting this hospital constructed." He called the new Cherokee Indian Hospital "one of the best-designed, most advanced health facilities in rural America."

Built near the administrative hub of the Cherokee Indian Reservation — which is located deep in the heart of the lush North Carolina Smoky Mountains — the new 80,000 sq. ft. facility will serve a population of approximately 8,800, and will employ more than 150 IHS and tribal personnel.

Equipped with some of the most modern, sophisticated medical apparatus available, the hospital will provide Cherokee residents with a full range of comprehensive health care services. These include facilities and equipment for general medical services, physical therapy, otitis media, laboratory, radiology, human services, audiology, community health nursing, health education, environmental health, and nutrition.

The hospital's inpatient facilities include a 2-bed intensive care unit, a 7-bed pediatric area, 15-bed general medical service, 2-bed security, 2-bed labor, and 4-bed obstetrical unit. The outpatient service area contains 19 screening, examination, and treatment rooms, including rooms for emergency medical care and casting. Ambulatory services include clinics for prenatal care, obstetrics, arthritis, orthopedics, and eye, ear, nose and throat checkups. The hospital also has a modern, 10-chair dental unit with capability for surgical, preventive, and restorative dental services.

Another major feature of the new Cherokee Indian Hospital is the solar heating equipment that, when fully

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EASTERN CHEROKEE PRINCIPAL CHIEF John A. Crowe (right), pictured here with IHS Director Dr. Emery Johnson (left) and National Indian Health Board Chairman Howard Tommie (middle), was instrumental in efforts to secure funding for planning and construction of the Cherokee Indian Hospital.

Eastern Cherokee . . .

Continued from Pg. 14

operational, will supply about 60 percent of the hospital's heating and hot water needs.

Despite these extensive capabilities, Johnson told the dedication audience that "any hospital is only one of several links in what is needed for comprehensive quality health care in a community." Johnson emphasized the need for a strong family structure, good housing, sound tribal management, and other supporting programs as important elements to overall health care.

Noting that such factors are presently evident throughout the Cherokee community, Johnson concluded that "the Cherokee people are facing a bright and prosperous future" in terms of health care. ■

Indian Water . . .

Continued from Pg. 13

Recently, a GAO study found that IHS' inability to provide these funds on an ongoing basis has led to the deterioration of equipment on certain reservations. The GAO report concluded that while the General Counsel's opinion was reasonable, another conclusion can also be reached from reading the legislation — that IHS does have operation and maintenance authority under P.L. 86-121.

The conference group agreed to pursue this matter with IHS. It was recognized that even if IHS got operation and maintenance authority, it could not fund all such programs on all reservations on a continuing basis. The cost would be so high that there would be no money left for setting up new systems.

Therefore, the group agreed to see if some guidelines could be written which would allow IHS to be involved in the operation and maintenance area without opening up a Pandora's Box. NIHB will be working with IHS and the Intertribal Council of Arizona to follow up on these matters.

Aberdeen Chairmen Appoint Austin Gillette as New NIHB Area Representative

NEW TOWN, N.D.—The National Indian Health Board (NIHB) announced that the Aberdeen Area Tribal Chairmen's Association has appointed Austin Gillette to serve as NIHB representative from the Aberdeen Area. Norman Wilson will serve as the NIHB alternate from the area.

NIHB has been without representation from the Aberdeen area since the Four State Area Indian Health Board was disbanded in April, 1979. According to both Gillette and Wilson, the appointments were the direct result of considerable concern by the area's tribal chairmen and health boards for more comprehensive health programs, tribally-run health clinics, new hospitals and effective impact on national Indian health policies.

Gillette, Chairman of the Fort Berthold Tribal Business Council and president of the United Tribes of North Dakota, is a member of the Mandan, Hidatsa and Arikara tribes. He has a bachelor of science degree from Minot State College in social science and a master's degree from the University of North Dakota in guidance and counseling.

Gillette said some of his area's health concerns are to increase the Medicare and Medicaid payments to the tribes directly and to try to create more alcohol treatment centers on the area's reservations. "We are also concerned with national representation and if you want strength in representation, this is the way to go," said Gillette.

According to Wilson, president of the Rosebud Sioux Tribal Council, the area health board was dissolved last year because of administrative problems, but that an investigation into the feasibility of a new area health board is currently underway. ■

Tribes and groups interested in this issue should contact NIHB to participate in this activity.

Lastly, the Blackfeet Tribe and the Colorado River Tribe made presentations on problems and accomplishments they have had in the water and sanitation area. The Colorado River representative talked about the joint funding project the tribe has just put together to build an extensive water and wastewater system on the reservation. The \$4.5 million program is being funded by five different agencies — IHS, BIA, EDA, FmHA and EPA. It was agreed that the Colorado River model is a valuable one. IHS was asked to write up the steps the Colorado River Tribe went through to pull together this program so it can be disseminated to other tribes who wish to replicate the Colorado River model.

It was the conclusion of the group that water and sanitation is an important, often expensive, and generally overlooked priority area for tribes. Yet, the water and sanitation systems for a reservation often determines what that reservation will look like — whether houses will be clustered or dispersed, where and what kind of industry can be attracted, etc. The group agreed that they will continue to work together and perhaps set up some formal structure under the joint sponsorship of NIHB and the Intertribal Council of Arizona to focus on continuing water and sanitation needs of Indian tribes. ■

President . . .

Continued from Pg. 2

provisions of the law, said the Mental Health Systems Act gives tribes an important new opportunity to manage their own health care services. The provisions, he said, were the result of efforts by a number of organizations and individuals, including the California Rural Indian Health Board (CRIHB), Sen. Edward Kennedy (D-Mass.), Sen. Alan Cranston (D-Calif.) and Rep. Henry Waxman (D-Calif.).

The National Indian Health Board will work closely with NIMH on developing regulations to implement the Mental Health Systems Act, Press said. He added that NIMH will probably be ready to receive grant applications by May, 1981.

Under Title II of the law, tribes and Indian organizations are eligible for grants to provide mental health care services to severely mentally disturbed children and adolescents, the elderly, and priority populations. In addition, they can apply for "linkage" grants, which provide for mental health care personnel and expanded services to existing health care centers, including IHS clinics.

NIMH grants for these services can be awarded for up to eight years, on a decreasing scale. For example, NIMH may fund a mental health program at 90 percent of the total costs the first two years, 80 percent for the third year, 70 percent for the fourth year, and so on. However, applicants will be required to indicate funding sources for the balance of program funds, and establish how the program will be financed upon completion of NIMH funding.

In a separate matter, P.L. 96-398 provides for equal special pay allowances for physicians in the U.S. Public Health Service Commissioned Corps and physicians in the armed forces. The provision affects the pay structure of nearly 500 physicians serving with the Indian Health Service, and overrides earlier legislation (P.L. 96-284, the Uniformed Services Health Professionals Special Pay Act) that established lower rates of special pay for Commissioned Corps physicians. The new provision providing for comparability in special pay rates has "provided a tremendous boost in the morale of IHS doctors," according to Dr. James Felsen, IHS Chief Medical Officer.

Copies of the Mental Health Systems Act can be obtained from the Senate or House documents rooms, or by writing the NIHB Public Information Office; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. ■

Noted IHS Diabetes Consultant Dies From Stroke

Kelly M. West, M.D., a prominent Oklahoma physician who served as a consultant to the Indian Health Service (IHS) on the problems of diabetes among Indians, died following a stroke in Hong Kong on July 29.

Dr. West distinguished himself over the past 25 years as a teacher and researcher at the University of Oklahoma, where he was professor of biostatistics and epidemiology at the University's Health Sciences Center. West was also a George Lynn Cross research professor and chairman of the Internal Diabetes Epidemiology group.

Much of Dr. West's research centered on the problems and causes of diabetes among Indians in both North and Central America. He was awarded a special grant from the National Institute of Health for research into causes of diabetes and obesity in Oklahoma Indians.

Dr. West's contribution to research, particularly in the field of epidemiology of diabetes, was extensive. He is credited with more than 150 publications in medical journals around the world. His article, "Diabetes: An Increasingly Dangerous Threat to Native American Health," appeared in the March, 1980, issue of the *NIHB Health Reporter*. ■

The NIHB Health Reporter is published monthly by the National Indian Health Board. NIHB is pleased to provide this newsletter to our readers throughout the country and welcomes the further distribution of the information contained therein. We do kindly request, however, that NIHB receive credit for articles reprinted from the NIHB Health Reporter.

Please submit all articles, correspondence and mailing requests to John P. O'Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200, Denver, Colo. 80231.

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