



NIHB Health Reporter

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More Cutbacks Likely for Indian Health Programs in FY 1983

WASHINGTON, D.C.—Indian health officials across the country, already beleaguered by the confusion surrounding this year's federal budget, are bracing themselves for more bad news as the Administration and Congress begin the political tussle over the 1983 fiscal year budget.

Administration officials here have been working feverishly to complete details on a fiscal year 1983 budget that will seek additional cuts in a number of health and social programs. Specific figures on the Administration's budget will not be known until after February 8, when the President is expected to present the spending plan to Congress.

Although precise funding levels for the Indian Health Service (IHS) are still unknown and have been "changed almost every day" for the past few weeks, according to one IHS official, early indications are that the Administration will recommend no increases for Indian health care in 1983.

According to one report, the Office of Management and Budget (OMB) proposed that IHS take a 15 percent reduction in the 1983 budget that was originally requested by the Department of Health and Human Services (DHHS). DHHS Secretary Richard S. Schweiker is reported to have appealed this and other OMB cuts, calling them "unwise and inappropriate."

Schweiker said the Indian health program "reflects our treaty obligations" to American Indians and that restoring the money would allow the Department "to fulfill its obligations without a reduction in services." Without increases to offset the inflationary costs associated with hospital and health care, agency officials claim that IHS and tribally-administered health clinics cannot maintain the same level of services provided in past years.

Recent indications are that the Administration will recommend a FY 1983 budget for IHS that provides funding levels close to those contained in the FY 1982 budget (approximately \$600 million for health services), with major reductions slated for the Community Health Representative (CHR) program, urban Indian health projects, preventive health services, Indian health scholarships, and construction of health and sanitation facilities.

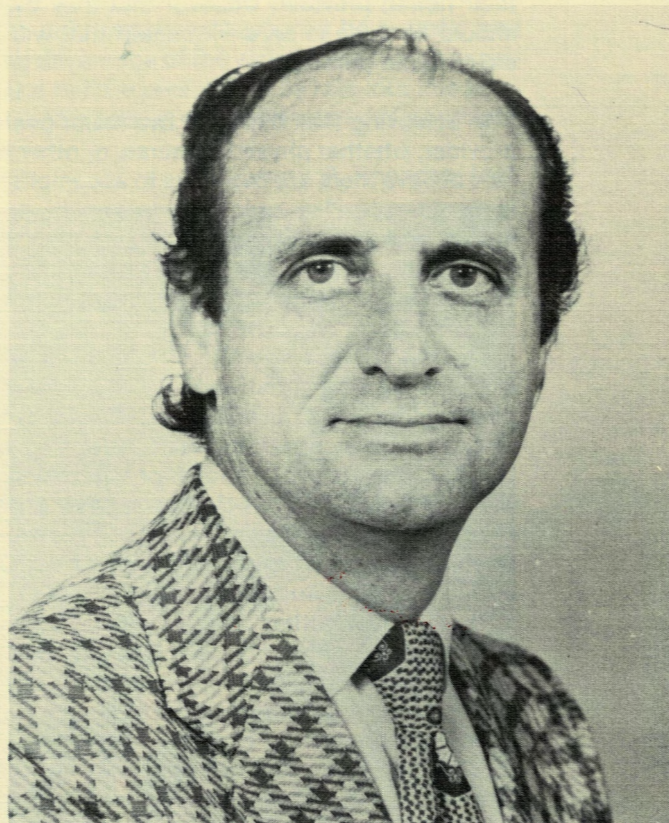
In addition, tribal and urban Indian health programs that rely on federal sources other than IHS would experience an even greater crunch. According to several reports, the Administration will recommend merging several federal health programs into block grants to states and then slash the total for all the blocks. Included in the proposal would be the nutrition program for women, infants, and children (WIC) and the family planning program, both of which are

essential to a number of tribal and urban Indian health projects.

Block grants are an integral part of the Administration's "New Federalism" plan for shifting numerous federal responsibilities—including many for health, social services, welfare, and education—to state and local governments. President Reagan has decided to accelerate this shift of responsibilities and will request an expansion of block grants and other major "New Federalism" programs in 1983.

Indian tribes protested the block grant proposals last year, arguing that state agencies administering the grants would refuse tribes their share of the resources and that

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DR. EVERETT R. RHOADES assumed the position of Director of the Indian Health Service on February 1. Rhoades, a member of the Kiowa Tribe of Oklahoma, has been active in Indian affairs throughout his medical career. He presents some of his views on his new responsibilities in an open letter on page 2.

New IHS Director Offers Views on Indian Health Care

On February 1, Dr. Everett R. Rhoades assumed the position of Director of the Indian Health Service. Dr. Rhoades is a noted physician, a Professor of Medicine, and Chief of the Infectious Diseases Section at the University of Oklahoma Health Science Center. In addition to his medical background, Dr. Rhoades has a history of involvement in Indian activities at both the national and local level. Nationally, he is recognized as an authority on Indian health issues, is a member of many medical organizations, and has participated in numerous projects to benefit Indian people across the country. As a member of the Kiowa Tribe of Oklahoma, Dr. Rhoades has served on the tribal business council and the tribal land management committee.

In his capacity as Director of the Indian Health Service, Dr. Rhoades will be responsible for the operation of a comprehensive health services system that provides care to more than 750,000 American Indian and Alaska Native people. We asked Dr. Rhoades to comment on his views of the Indian Health Service and the role of the Director. He agreed, and responded with the following letter:

Thank you for your recent inquiry about my philosophy regarding the Indian Health Service. I welcome the opportunity to communicate this to your readers. It would be presumptuous of me and even potentially misleading if I were to list at this moment priorities for the Indian Health Service. I plan to take several weeks in order to thoroughly educate myself about all aspects of the operation of the Indian Health Service and then I will be able to set specific goals that I hope to achieve in order to bring about improvement in the health of Indian people.

My nomination to this important post has caused me to ponder extensively my own philosophy regarding the health of Indian people. The most important consideration, I believe, is the insuring that every single encounter between each Indian man, woman and child and their health provider, whoever that may be, should be the best that can be achieved. This should be done in an environment that will insure the highest level of health attainable for each Indian person.

In achieving this, there are two major goals to accomplish. One is to insure that the health provider, whether physician, nurse, or other health worker, is the very best that can be provided. I believe there are two ways to accomplish this. One is to recruit the best people to care for Indian people. The second is to provide an atmosphere and an environment in which the health worker can exercise a high degree of skill in a manner which is both rewarding and stimulating. I believe the Indian tribes possess the best means, and in many cases almost the only means, of providing a suitable atmosphere for the health worker.

There is a great diversity of interested parties, organizations and individuals, both within and outside the Indian Health Service, who are involved in Indian health care. As a second major goal, I visualize the role of the Director of Indian Health Service to coordinate these various forces in a concerted, organized effort so that the various tribal programs, health boards, health committees of national or regional Indian organizations, appropriate specialized staff within IHS, the area directors, and other appropriate individuals can be assured that all their diverse efforts are moving in the same direction. I find the opportunity to facilitate these different talents and movements one of the most exciting aspects of the Directorship.

There are two other areas in which I believe the Indian Health Service can fulfill an important mission for Indian people. One of these is to provide a system whereby young (or, for that matter, old) Indian people can enter into a career of service to other individuals in some medical field. I subscribe to the general idea that the most significant need for Indian people is economic security. I believe this is an integral aspect of good health. I believe that the various disciplines in the health fields provide important areas in which economic security for individuals can be achieved. It is my hope that the Indian Health Service can serve as a conduit for those Indians who wish to pursue a career in a health field.

Finally, my years of experience on my own tribe's council have illustrated to me time after time that the greatest Indian need presently *on an organizational basis* lies at the tribal level. I believe that the integral unit of Indian organization is indeed the tribal. My experience has

been that tribes are often unable to meet the extraordinary demands of functioning in today's world. Indeed my major concern in the years I served on my own tribe's council, other than modest efforts at improving health care, had been to strengthen and make more representative and responsive tribal government to each individual tribal member. Extensive conversations with knowledgeable people who have served on other tribal councils suggest that my experience and concerns are not unique. During the tenure of Dr. Johnson, the Indian Health Service played a pioneering role in efforts to strengthen tribal integrity. The United States Congress in the enactment of Public Law 93-638, the Indian Education Assistance and Self-Determination Act, laid the basis for a national emphasis on Indian self-determination. I intend fully to push forward on those programs that will further Indian self-determination within the limits that are expressed by each individual tribe itself.

It is exciting to contemplate the many ramifications of the above topics, but an exhaustive discussion is beyond our present space. I hope that in summarizing these rather broad areas that I have not been misleading in any way.

The essential points of my life have been outlined in several directories and biographical sketches. I am a product of a rural Indian community, brought up in an Indian church and have actively participated throughout my adult life in the various cultural events of the Kiowa Tribe. My close associates within that tribe, who know me best, can attest to the fact that, in fact, I am a grass roots Indian. I am acutely aware of the significance of my appointment as the first Indian Director of the Indian Health Service. It goes without saying that this imposes more than ordinary responsibility upon the Director. I sincerely hope that I can conduct this office in such a way that all those great departed Indian people have tried to do in a lifetime of dedication to Indian people. I hope those Indians who are living today and those who will follow us will be able to say that the Assistant Secretary for Health indeed made a happy choice for this important position.

I believe that every individual and especially every Indian individual is unique and I respect each person for what they are. I think each person should have the opportunity of contributing something worthwhile to the whole group. Sometimes this is not possible. We have to work to find ways to make it more nearly always possible. I have had many disagreements with a variety of people active in Indian affairs, but the only people with whom I have really had disputes are those who, in my opinion, were taking advantage of the very people that they proposed to serve. It is my privilege at the present time to have been thrust by fate into this position and I shall approach the task with hard work and a feeling of good wishes for all people.

Everett R. Rhoades, M.D.



NEW IHS DIRECTOR Dr. Everett Rhoades chats with nephew Rick Kupke, the Kiowa Indian who was among the Americans held hostage in Iran, during retirement ceremonies for former IHS Director Dr. Emery Johnson.

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 briefs on issues and activities from around the country that relate to Indian health care, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on items mentioned here can be obtained from the NIH Public Information Office.

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PHOENIX, ARIZ.—The Senate Select Committee on Indian Affairs will hold a field oversight hearing on the Indian Health Service (IHS) here February 15. Senator Dennis DeConcini (D-Ariz.) will chair the hearing, which is being held to examine the impact of the 1982 budget cuts on IHS and tribal health programs in the state of Arizona. Invitations to testify at the hearing are being sent to IHS officials, tribal health departments, Indian alcoholism programs, and urban Indian projects in the Tucson, Phoenix, and Navajo IHS areas, according to Senate committee staff person Jo Jo Hunt.

The hearing will be held at the Maricopa County Board of Supervisors Auditorium at Third Avenue and Jefferson Street in Phoenix. For additional information contact Jo Jo Hunt with the Senate Select Committee on Indian Affairs (202) 224-2251.

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GRAND FORKS, N.D.—Diabetes and the American Indian will be the theme of a two-day conference sponsored by the Indians Into Medicine (INMED) Program here February 11-12 at the University of North Dakota. Sessions will cover innovations in diabetes mellitus testing and treatment, and current research on the disease. Special attention will be given to the epidemiology of diabetes among Indian people. In some tribes, the rate of adult onset diabetes is 10 to 15 times greater than that of the general population. Presentations about reservation-based diabetes clinics and research among Indian people will be given during the conference. Topics to be covered include: diabetes and pregnancy; diabetes and infectious diseases; types and uses of insulin; recent advances and genetic factors. Several Indian health professionals will be among the presenters. For more information contact: the INMED Diabetes Conference, Box 173; University Station; Grand Forks, N.D. 58202 Phone: (701) 777-3037.

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BETHESDA, MD.—The National Health Screening Council (NHSC) is seeking a Native American coordinator for its minorities health fair program. The NHSC offers free health screening and health education to local communities. The Native American coordinator will serve as a liaison with Indian organizations, assist with newsletter announcements, and provide training and orientation for the health fair model. Starting salary is \$17,000 and ability to travel is necessary. To apply, send resume and references to: Lila Suna, Director, National Programs;

NHS-CVO; 5161 River Road, Building 2; Bethesda, MD. 20816 Phone: (310) 657-8480 or (toll free) 800-638-8087.

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Porvaznik

TUCSON, ARIZ.—Dr. John Porvaznik, Acting Director of the Navajo Area Indian Health Service (IHS), was named the IHS Outstanding Clinician by the National Council of Clinic Directors (NCCD) at the group's annual meeting here in early December. According to NCCD Chairman Dr. Terry Sloan, Porvaznik was cited for his "outstanding medical contributions to Indian health care. His work has had a significant impact on grassroots health care

delivery." Since entering the Indian Health Service in 1962, Porvaznik has had a distinguished career as a physician and surgeon and is presently the IHS Senior Clinician for Surgery. A graduate of Harvard Medical School, Porvaznik has spent his IHS career working at different health facilities on the Navajo Reservation and has been honored by the tribe on several occasions for his contributions to the Navajo people.

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WINDOW ROCK, ARIZ.—The Navajo Vocational Rehabilitation Program has expanded its services to provide recreational opportunities to the Navajo disabled population. The goal of the new "Navajo Handi-Rec Program" is to enhance the "total fitness" of each handicapped individual, help them become aware of their talents, and encourage a positive self-concept through recreational activities. To obtain more information about the project, contact: Mary Jane Gallahan, Director; Handi-Rec Program; Navajo Vocational Rehabilitation Program; P.O. Box 1420; Window Rock, Ariz. 86515.

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WHITE RIVER, ARIZ.—Carla Baha Alchesay became the first woman and first member of her tribe to be named director of the White Mountain Apache IHS hospital here. The hospital has a budget of more than \$5 million and employs 231 persons. IHS Phoenix Area Director Dr. George Blue Spruce said that Alchesay "brings to her position the sensitivity and knowledge of the White Mountain Apache people. She can use that as a strong basis for giving her people what is most needed and...determine the directions that should be taken to give the people the best possible health care."

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RENO, NEVADA—American Indian college students who have completed their freshman year are eligible to apply for the Summer Preceptor Program at the University of Nevada, Reno. Students work for two weeks as part of an

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inter-disciplinary health care term that provides health screening services to remote Indian reservations in Nevada. Deadline for application is July 1, and the preceptorship runs from mid to late August. For further information contact: the Health Career for American Indians Program; University of Nevada, Reno; Room 205-207 Mackey Science Building; Reno, Nevada 89557 Phone: (702) 784-4936.

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WASHINGTON, D.C.—Health-care costs in the United States rose 12.5 percent in 1981, an increase that outpaced the overall inflation rate, according to recent government statistics. Figures showing the 1981 consumer price index were released on the heels of an appeal from Health and Human Services Secretary Richard S. Schweiker for support of a "competition" plan for curbing health-cost increases. Schweiker said that a well-publicized voluntary program by health-care providers to hold down their own costs "certainly isn't working." The competition plan advocated by Schweiker is designed to prompt use of different kinds of health-care service delivery.

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WASHINGTON, D.C.—Art Raymond, Oglala Sioux, has been reappointed to a three-year term on the National Diabetes Advisory Board. The 18-member board was established by Congress to oversee long range federal policies to promote prevention, treatment, and research on diabetes. Raymond, the only Indian board member, is currently director of Indian Program Development at the University of North Dakota.

More Cutbacks...

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Indians would be unfairly denied services provided by the grants. Although five of the seven DHHS block grants for 1982 permit certain tribes to bypass the state grant process and apply directly to Washington for funding, the eligibility criteria is so stringent that only a few tribes qualified for direct funding this year.

The President's request for the Indian Health Service, block grants, and the hundreds of other federal government programs are only recommendations, and must still be reviewed and approved by Congress. The Congressional budget process, which takes eight months or longer to complete (see inset for timetable), was established to allow Congress to set priorities for overall federal spending. Although this process was beset by confusion and delays last year, and the Administration succeeded in pushing through several controversial budget initiatives, Capitol Hill observers predict that Congress will have a much stronger hand in shaping the federal budget for 1983.

Tribes and Indian organizations will have their first opportunity to officially comment on the President's budget proposals at hearings before the House and Senate Appropriations Committees, which will probably be scheduled for late February. For additional information, contact the House Interior Subcommittee on Appropriations (202/225-3081) or the Senate Interior Subcommittee on Appropriations (202/224-7262). ■

GALLUP, N.M.—The Indian Health Service (IHS) and the University of New Mexico jointly sponsor a program here to train physicians assistants. The physicians assistants are trained to perform many of the preliminary tasks done by physicians, including selected diagnostic and treatment procedures. While in the program, students are employed by IHS at a minimum salary of \$12,800 per year. Applicants to the program must have a high school diploma or equivalent, and three years experience or education in a health field. For further information contact: Allied Health Education; P.O. Drawer L; Gallup, N.M. 87301. ■

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FY 1983 Congressional Budget Process: Timetable*

February 8	President submits budget for upcoming fiscal year.
late February	House, Senate Interior Subcommittees on Appropriations hold hearings for outside witnesses (tribes, Indian organizations).
April 1	Congressional Budget Office reports to budget committees on President's recommendations, alternatives.
April 15	Budget committees report first budget resolution.
mid-June to mid-July	House, Senate Interior Subcommittees on Appropriations complete action on bills.
September 13 (seventh day after Labor Day) ...	Congress completes action on second budget resolution.
September 25	Congress completes actions on reconciliation bill, if required by budget resolution.
Before October 1	Congress sends all appropriations to President.
October 1	New fiscal year begins.

* As established in the Congressional Budget Impoundment and Control Act of 1974. When Congress is unable to approve the regular appropriations bills before the fiscal year begins, it must rely on a continuing resolution, which allows the government to spend money for a specified period at the existing or some other specified rate.

NIHB Elects New Executive Officers

FORT LAUDERDALE, FLA. — Representatives of the National Health Board (NIHB) elected a new slate of officers to its Executive Committee during the board's quarterly meeting here last fall.

NIHB's new executive committee is: Tony Secatero, Albuquerque area representative, Chairman; Timm Williams, California area representative, Vice-Chairman; Donald LaPointe, Bemidji area representative, Secretary; Lawrence Snake, Oklahoma City area representative, Treasurer; and Maxine Dixon, NIHB representative from the United South and Eastern Tribes (USET), Member-at-large.

Secatero, the Board's new chairman, says that many of the present difficulties facing Indian Health Service (IHS) and tribal health programs are related to funding. He indicated that it is imperative for Indian people to become more actively involved in the preparation of their local and area-wide health budgets, especially with the present Administration's efforts to reduce federal spending.

"Tribes need to work closely with Indian Health Service at all levels, so that we understand how these cuts will affect the health care of our people. We must work together on new directions and changes that will help meet the health needs of Indian people," Secatero said.

As tribal health director of the Canoncito Band of Navajos, Secatero has had eight years of experience in health administration and planning. He wrote Canoncito's Tribal Specific Health Plan (TSHP), and helped put together the Albuquerque area health plan. Secatero also serves as secretary/treasurer for his tribal council, and is chairman of the Albuquerque Area Indian Health Board.

NIHB Vice-Chairman Williams, one of the organization's original founders, stressed the need for improving the management and delivery of health services to Indian people.



NEW NIHB OFFICERS are (l-r, top) Timm Williams, Vice-Chairman; Donald LaPointe, Secretary; Tony Secatero, Chairman; (l-r, bottom) Maxine Dixon, Member-at-large; and Lawrence Snake, Treasurer.

ple. He said particular attention should be given to the question of how IHS resources can be most equitably distributed nationally to meet the health needs of Indian people.

Williams, a Yurok Indian from Crescent City, Calif., is chairman of the California Rural Indian Health Board (CRIHB), a position he has held for the past five years. He has been actively involved in Indian issues on local, state and national levels for the past five years, and was special assistant on Indian affairs to Governor Ronald Reagan in the early 1970's. In 1972, Williams was named "Man of the Year" by the National Academy of Pediatrics.

LaPointe, a Chippewa from Houghton, Mich., has held the office of NIHB Secretary in the past and has long been involved in the field of health, having worked with the state mental health department for eight years. Although the Bemidji area (Michigan, Wisconsin, Minnesota, and Iowa) does not have an active health board, the Four State Inter-Tribal Assembly, which is comprised of the 29 tribes in the area, serves as the official area organization to NIHB and selected LaPointe as its area representative.

In his capacity as NIHB Treasurer, Snake will take an active role in the organization's fiscal operation. He served last year as NIHB's Vice-Chairman, and is presently vice-chairman of the Delaware Tribe of Western Oklahoma and chairman of the Oklahoma City Area Indian Health Board.

Maxine Dixon, the board's member-at-large, is the NIHB representative from the United South and Eastern Tribes, which is comprised of 12 tribes from the states of Maine, New York, North Carolina, Florida, Mississippi, and Louisiana. She is a member of the Mississippi Choctaw Tribe, a tribal council member, and chairs the tribe's health committee. ■

NATIONAL INDIAN HEALTH BOARD

1602 South Parker Road, Suite 200
Denver, Colorado 80231

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Preventive Medicine, New Legislative Proposals Set as Major Items for Indian Health Conference Program

TUCSON, ARIZ. — Amid further budget cuts and other Administration policy directives predicted for the next fiscal year, Indian health programs across the country will likely be forced to make substantial changes in the delivery of health care services to Indians and Alaska Natives.

In an effort to address these changes and other important issues affecting the health care of Indian people, the National Indian Health Board (NIHB) will sponsor the Fifth National Indian/Alaska Native Health Conference here April 19-22, 1982.

The conference will provide attendees with the most up-to-date information available on the Administration's budget and legislative proposals, and will give the participants an opportunity to express their concerns about the future of Indian health services.

As indicated by the conference theme—"Preventive Medicine—The Key to the Future"—this year's forum will focus particular attention on the role health preventive measures play in treating diseases such as diabetes, alcoholism, hypertension, heart disease and other health problems affecting American Indian and Alaska Native populations.

This year's emphasis on preventive medicine is largely the result of numerous suggestions submitted to NIHB since last year's conference in San Diego, Calif. Many of the recommendations have requested that more attention be given to specific diseases and health problems found in Indian communities. In response to these concerns, the conference will offer workshop topics such as Fetal Alcohol Syndrome, Cancer, Alcohol and Drug Abuse, Diabetes, Physical Fitness and Nutrition, Suicide Preven-

tion, Hypertension and Heart Disease, Emergency Medical Services, End Stage Renal Disease, Dental Care, and Breastfeeding. Each workshop will focus especially on preventive measures that can be utilized in treating these health problems.

In keeping with last year's conference theme dealing with Indian Self Determination, efforts are being made to utilize speakers from Indian projects that have successfully incorporated preventive health practices into their services. By featuring such speakers at the conference, it is hoped that certain Indian programs can be seen as models for tribes interested in developing similar health services.

Other conference workshops will touch on different aspects of health care, program management, and health administration, including: Traditional Indian Medicine; Health Care Appropriations and the Legislative Process; Alternate Resource Development; Improving Patient-Physician Interaction; Diseases Related to Environmental Health; Health Issues Affecting the Elderly; Developing and Operating a Tribal Health Program; and Health Careers.

In all, the conference will feature 19 highly specialized workshops in addition to two large general assembly sessions. Conference participants will be encouraged to share their own knowledge and experience with others and to help develop solutions and recommendations for action by tribes, local Indian communities, Indian organizations, and the federal government.

The importance of proper care and prevention will be further emphasized at a special conference Health Fair,

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Conference Notes...

The center of this issue contains a special insert for the Fifth National Indian/Alaska Native Health Conference, which will be held in Tucson, Ariz., April 19-22, 1982.

The insert is designed to provide necessary forms for those wishing to pre-register and make hotel arrangements for attending the conference. Pre-registration is \$44, and should be sent to the National Indian Health Board (NIHB) central office by March 31, 1982. Registration at the conference site is \$48. Additional forms can be obtained from the NIHB central office.

To help offset conference costs, NIHB is sponsoring a special conference raffle with Indian paintings, arts and crafts, and other gifts to be presented at the conference. Raffle tickets can be purchased for \$1. Persons interested in selling raffle tickets should contact the NIHB central office. Raffle winners need not be present to receive their prizes.

In addition, conference posters are now being printed

and will be available in early February. The posters—which are large and colorful, and feature the work of Papago artist George Garcia—can be purchased from NIHB for \$5; proceeds from these sales will be used to help cover printing and postage costs.

Travel arrangements can be made through Free Spirit Travel (3005 S. Parker Rd.; Denver, Colo. 80014), which can arrange special discounts on air fares, group travel, tours, etc. To make reservations, call collect at (303) 751-7200.

Finally, NIHB has received several recommendations for individuals to receive special recognition at the conference for their contributions to Indian health care. Nominations for such recognition are still being accepted and should be submitted as soon as possible. Nominations should include an explanation of how the individual, organization, or tribe contributed to improving the health care of Indian people. Awardees will be presented with special plaques or medallions at the conference.

Alcohol and Pregnant Women's Drinking Habits Often Prove

Each year thousands of babies are born in this country with a serious health problem that cannot be cured, but could easily have been prevented. This condition, known as the Fetal Alcohol Syndrome (F.A.S.), is the direct result of women drinking alcoholic beverages during pregnancy. Children born with Fetal Alcohol Syndrome frequently suffer from various degrees of mental retardation, growth deficiency throughout life, disorders of the central nervous system, and other abnormalities. The syndrome is considered to be the second most frequent birth defect in the United States, and is emerging as the leading cause of mental retardation in the Western world.

Although the dangers of drinking during pregnancy have been suspected for hundreds of years, it was not until 1973 that a pattern of malformations in babies born of alcoholic mothers was fully described

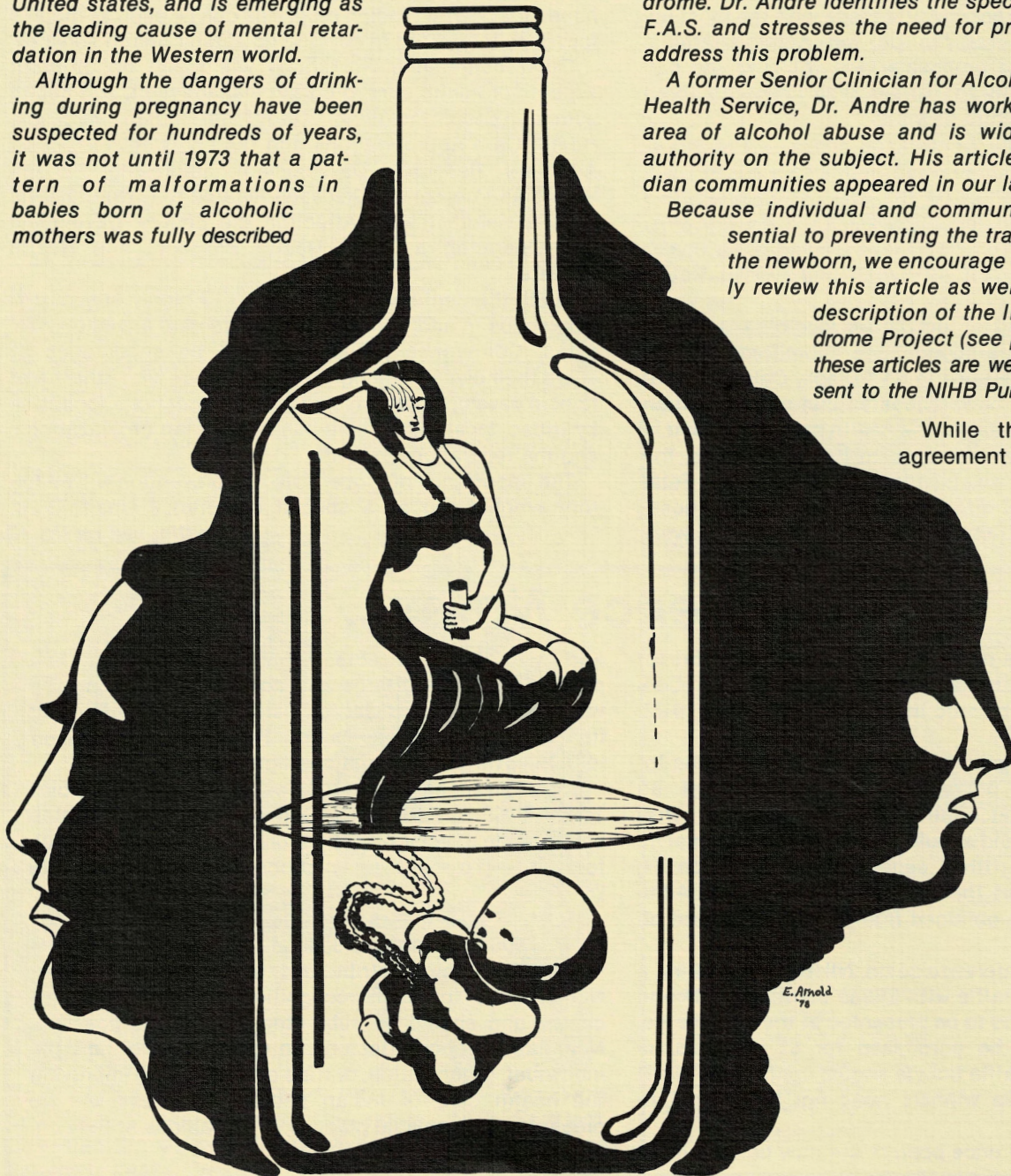
and identified as Fetal Alcohol Syndrome. Medical studies have clearly demonstrated that the consumption of alcohol interferes with normal pregnancy, and that the effects on the fetus are permanent. Moreover, statistics indicate that the incidence of F.A.S. is widespread, and is particularly high in certain American Indian communities.

In the following article, James M. Andre, M.D., M.P.H., summarizes the effects of ethyl alcohol (ethanol) on the developing fetus in women who drink during pregnancy, and focuses particular attention on Fetal Alcohol Syndrome. Dr. Andre identifies the specific characteristics of F.A.S. and stresses the need for preventive measures to address this problem.

A former Senior Clinician for Alcoholism with the Indian Health Service, Dr. Andre has worked extensively in the area of alcohol abuse and is widely respected as an authority on the subject. His article on alcoholism in Indian communities appeared in our last issue.

Because individual and community awareness is essential to preventing the tragedy of F.A.S. among the newborn, we encourage our readers to carefully review this article as well as Dr. Phillip May's description of the IHS Fetal Alcohol Syndrome Project (see pg. 11). Comments on these articles are welcomed, and should be sent to the NIHB Public Information Office.

While there is no clear-cut agreement among physicians on



An Invitation to the

Fifth National
Indian/Alaska Native
Health Conference

Tucson Community Center

Tucson, Arizona

April 19-22, 1982

Sponsored by the National Indian Health Board

April 19-22, 1982

Tucson, Arizona 85726

IMPORTANT: Please make all reservations through the Housing Bureau. Rates quoted will be guaranteed only through the Bureau. To ensure availability and quoted rates, Reservations must be received by **March 20, 1982**. Reservations accepted only on an official housing form.

Deposit information will be sent with your confirmation from the hotel. The bureau does not accept deposit. Rooms are not held after 6:00 PM unless guaranteed by one full night's deposit. The bureau does not accept telephone reservations. Cancellations and changes may be made directly to the bureau 15 days prior to meeting dates. During the last 15 days, all cancellations and changes must be made directly to hotel.

PLEASE PRINT OR TYPE ALL INFORMATION BELOW:

Arrive: _____ Time: _____ Depart: _____ Time: _____

NAME _____
(LAST NAME) (FIRST NAME)

ADDRESS _____
(CITY) (STATE) (ZIP) (AREA CODE/PHONE NUMBER)

SHARING ROOM WITH _____ HOTEL CHOICE: 1. _____
 _____ 2. _____
 _____ 3. _____

TUCSON HOTEL LISTING

	SINGLE	DOUBLE		SINGLE	DOUBLE
TUCSON MARRIOTT HOTEL	\$34.00	\$34.00	LA QUINTA	\$32.00	\$32.00
180 West Broadway			665 North Freeway		
Tucson, Arizona 85701			Tucson, Arizona 85705		
(Headquarters Hotel Walking			HOLIDAY INN/NORTH	\$26.00	\$26.50
Distance Convention Center)			1385 Grant Road & I-10		
SANTA RITA HOTEL	\$34.00	\$45.00	Tucson, Arizona 85705		
109 South Scott Avenue			SAHARA MOTOR INN	\$22.00	\$24.00
Tucson, Arizona 85701			919 N. Stone Avenue		
(Walking Distance Convention			Tucson, Arizona 85705		
Center)			HILTON INN	\$32.00	\$38.00
RAMADA/TUCSON RESORT	\$27.00	\$33.00	1601 Miracle Mile Strip		
404 N. Freeway			Tucson, Arizona 85705		
Tucson, Arizona 85705			HOWARD JOHNSON'S		
(Walking Distance)			MOTOR LODGE	\$28.00	\$31.00
DESERT INN	\$24.50	\$28.50	Benson Ave. & Park Av.		
I-North Freeway			Tucson, Arizona 85705		
Tucson, Arizona 85705			PLAZA INTERNATIONAL	\$39.50	\$41.50
(Walking Distance)			1900 East Speedway Blvd.		
SHERATON PUEBLO/INN	\$33.00	\$39.00	Tucson, Arizona 85705		
350 South Freeway					
Tucson, Arizona 85705					
(Walking Distance)					

**Fifth National Indian/Alaska Native Health Conference
Tucson, Arizona
April 19-22, 1982**

“Preventive Medicine—The Key to the Future”

Date Received _____ Received by _____

cy: Mothers' Drinking Tragic for Newborn

diagnostic criteria for alcoholism, there is a clearly defined set of symptoms and signs that comprise the fetal alcohol syndrome with which every physician should become familiar.

Alcohol withdrawal syndrome in the newborn is based on the fact that alcohol freely crosses the placental barrier and enters the fetal blood stream. Where the mother consumes alcohol in significant amounts, the blood alcohol concentration of the fetus can be shown to approximate that of the mother. The result for the fetus is intoxication and increasing tolerance, followed by the alcohol withdrawal syndrome usually within hours after delivery. The severity of withdrawal varies with the degree and duration of exposure to alcohol.

Where the physician has taken a careful history, including an alcohol-drug history, the results for the fetus can be anticipated and treated accordingly. Where the mother's drinking history is unknown upon delivery, the physician, when confronted with a newborn in withdrawal, may entertain other diagnoses resulting in delay of proper treatment or no treatment at all. In this circumstance the infant may be subjected to a variety of diagnostic procedures (especially if a convulsion occurs) to rule out various disorders such as hypoglycemia, electrolyte disturbance or intracranial hemorrhage. At the minimum, the newborn will experience alcohol withdrawal "cold turkey."

There may also be various stages of liver disease in the newborn as a result of continued heavy exposure to alcohol in utero. These changes include fatty infiltration, alcoholic hepatitis, nodular regeneration and fibrosis.

In 1973, a University of Washington research team fully described a pattern of malformations in the offspring of chronic alcoholic mothers that has since come to be called *Fetal Alcohol Syndrome*. That these abnormalities are not genetic in origin but are likely due to the direct toxic effect of alcohol or its metabolites is demonstrated by other studies of children with the fetal alcohol syndrome but with normal chromosome patterns.

In the University of Washington study, eight unrelated children of different ethnic groups (including American Indian) born to mothers who were chronic alcoholics all had a similar pattern of altered growth and structural abnormalities. Of importance in this study is the fact that the mothers of these babies all satisfied the National Council on Alcoholism's criteria for alcoholism. All were known to have been excessive drinkers throughout their pregnancies and none was known to be using other drugs.

The findings of this and many subsequent reports on fetal alcohol syndrome are discussed below with some definition of terms for those readers without training in medical terminology. The list is a fairly complete accounting of those characteristics of fetal alcohol syndrome reported by a variety of sources, and no one case would exhibit all or even most of these characteristics. Please keep in mind that a child with some of these characteristics does not necessarily have FAS.

The tendency nowadays is to use the term *fetal alcohol effect* (FAE), whenever structural damage is less than that required for *fetal alcohol syndrome* (FAS).

Characteristic Features of FAS

Central Nervous System Dysfunction

✓ Microcephaly (small head) head circumference below the third percentile indicating lack of normal brain growth. Accelerated "catch-up" growth of the head postnatally does not occur. One researcher has described cases of FAS together with anencephaly (no head) and has even reported cases of hydrocephaly ("water head") with FAS.

✓ Mental retardation, the severity of which is correlated with the number and severity of other characteristics of FAS described below. The intelligence quotient is reported by one researcher to range from 15 to 105 in FAS cases, but averages 65. In a study in which the researcher followed 17 children with FAS over a one-to-four year period, it was found that the IQ remained unchanged in 77 percent of the cases. In those cases where the IQ changed, two increased and two decreased with the change being related more to age at testing than to the initial level of IQ. Those tested before and after entry into school showed an increase in their IQ.

✓ Fine motor dysfunction which includes tremulousness, poor eye-hand coordination, startle reaction and delay in establishing hand dominance. Since one major study reported a higher prevalence of alcoholism in parents of hyperactive children, some have considered that hyperactivity may be yet another manifestation of central nervous system dysfunction in FAS. This might be better called FAE rather than FAS; however not all cases of hyperactivity have a connection with maternal consumption of alcohol during pregnancy.

Growth Deficiencies

✓ Prenatal growth deficiency with birth length and birth weight well below normal.

✓ Postnatal growth deficiency with failure to catch up even in a controlled environment with special attention to nutrition. At least one study of growth hormone in children with FAS has not shown deficiency. For this reason, one researcher believes growth deficiency in FAS to be the result of a reduced number of cells in the fetus from which future cells would have developed. For these reasons, and because previous studies of undernourished mothers who were not alcoholic showed no offspring with FAS, the syndrome does not seem to be the indirect result of malnutrition in the mother and fetus.

Facial Abnormalities

✓ Eyes—short palpebral fissures (eye slits); micropthalmia (small eyes); epicanthal folds ("mongolian lids"); ptosis (drooping of the eyelid); strabismus (deviation of the eye); cataracts and retinal defects (rarely). Defects of the

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eyes are quite common in FAS cases, perhaps because the eye is an outgrowth of the central nervous system which is acutely sensitive to the effects of alcohol.

- ✓ **Facial Bones**—underdevelopment of the maxilla (upper jaw region) which results in a broad nasal bridge and flattened contour of the mid-face; protruding chin (more common), and receding chin (less common).

- ✓ **Mouth and Lips**—cleft palate; harelip.

- ✓ **Ears**—set low and tilted backwards; poorly developed concha (furrows).

Variable Major and Minor Malformations

- ✓ **Cardiac**—ventricular septal defect (hole in the dividing wall of the two ventricles); atrial septal defect (hole in the dividing wall of the two atria); patent ductus arteriosus (a connecting blood vessel between the pulmonary artery and aorta in the fetus which did not close off as it should after birth).

- ✓ **Limbs and Skeletal**—abnormal creases in the palms of the hands; campodactyly (permanent flexion of the fingers); clinodactyly (permanent deviation of the fingers to either side); syndactyly (webbing of the fingers); pectus excavatum (indented breastbone); rib abnormalities including malalignment and fusion; congenital hip dislocation; inability to completely extend the elbows; Klippel-Feil syndrome (fusion of cervical vertebrae with limitation of movement and shortness of the neck).

- ✓ **Genitals**—underdevelopment of labia majora; septate vagina (partitions in vagina); hypospadias (the tube from the urinary bladder opens on the underside of the penis in boys or into the vagina in girls).

- ✓ **Muscles**—poor muscle development and tone; diastasis recti (the vertical abdominal muscle bulges away from the middle); diaphragmatic defects with or without hernia; umbilical or groin hernias.

- ✓ **Skin**—hemangiomas (overgrowth of blood vessels in the skin); underdevelopment of fingernails; and hirsutism (overgrowth of hair on face and body).

Ethanol as Primary Cause

In early studies direct ethanol toxicity is considered the most obvious cause in producing the damage seen in FAS or in milder cases of FAE. One report showed a correlation between the amount of alcohol consumed by the mother and the risks run by the fetus (including spontaneous abortion and stillbirth). This was so even when other factors such as smoking, poor diet and relatively advanced maternal age were eliminated from consideration.

In none of these studies, however, could it be said with certainty that ethanol acts alone to produce FAS. It may yet be shown that certain metabolites of ethanol such as acetaldehyde or toxic substances in alcoholic beverages such as fusel oils damage the fetus either directly or in combination with ethanol. However, evidence to date still points toward ethanol or its metabolites as the most likely direct cause of the fetal alcohol syndrome.

That a relationship exists between the dose of alcohol and risk of damage to the fetus seems likely. One researcher found a definite relationship, with low doses producing damage to the central nervous system and increasing-

ly higher doses producing additional (and progressively more severe) malformation in other organs and tissues.

The recent recognition of fetal damage which is less than a full-blown fetal alcohol syndrome (i.e., FAE) would seem to lend support to these findings. According to one study, a high blood-alcohol level during a critical time in development (especially the first three months of pregnancy) could be more important in terms of risk than a high average alcohol intake throughout pregnancy. Unfortunately, this is a time when women may be pregnant and not even know it.

Simply stated, the pregnant woman who gets "loaded" at a party, even though only once in the entire pregnancy, might put the fetus at high risk for the FAS. The developing cells and tissues simply cannot tolerate a toxic chemical environment even for a few hours. This is of great importance in view of reports that although women decrease regular alcohol intake during pregnancy, binge drinking increases. If ever there was an example of intrauterine child abuse, FAE-FAS is it!

Obviously then the single best answer to the question of "safe" level is a *zero blood alcohol level*; if a woman is pregnant, suspects she's pregnant, is trying to become pregnant or even planning to become pregnant, she should avoid alcohol in any form.

The Case for Prevention

If ever there was a classic case for prevention, FAS or FAE is it. It is a condition which, for all practical purposes, is zero-percent curable yet 100-percent preventable. It is also expensive to care for.

There is a need to aggressively reach out to women in the child-bearing age groups through community education programs to make them aware of the fetal alcohol syndrome. Where drinking problems are found to exist, prompt treatment and careful follow-up should become part of prenatal care. Careful screening of newborns (and even older children) could result in identification of cases of FAS for whom something might be done. The reverse side of this is the identification of mothers whose degree of alcohol consumption was previously not recognized and who should have treatment and follow-up to help these women not repeat the tragedy.

Of special interest here is the establishment of a pilot program within the Indian Health Service in December, 1979, to identify existing cases of FAS and FAE, refer these children to treatment, estimate the prevalence of the problem and work toward prevention of further cases. This program (see related article pg.11) has been heavily involved in the training of physicians and others in early recognition of the problem and in community education to increase knowledge of the risk of FAS-FAE.

The project has successfully coordinated all treatment efforts for children having developmental defects including, but not limited to, FAS-FAE. This is done by a team of specialists from many disciplines, and the treatment efforts are focused on the mother as well as the child.

Of equal importance as training and treatment is the ef-

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Pilot Program Studies FAS Problems in Southwest Indian Communities

In an effort to more fully understand, treat, and prevent alcohol-related birth defects among Indian children, the Indian Health Service established a pilot Fetal Alcohol Syndrome Project in December of 1979. This pilot project, which conducts most of its work in the Albuquerque and Navajo areas of IHS, was designed to identify existing cases of Fetal Alcohol Syndrome, refer them to treatment, estimate the prevalence of the problem and work towards the prevention of future cases. Although the pilot project has been successful in these efforts, its continued existence is threatened by budget cutbacks. The project is currently operating on an extension through early March. Below, project director Philip May, Ph.D., describes the work carried on by the project.

ALBUQUERQUE, N.M.—Fetal Alcohol Syndrome is a pattern of malformations which is found in children born to mothers who drink alcohol excessively during pregnancy. The most common features of this syndrome include: various degrees of mental retardation, small size in birth length and weight, microcephaly, hypoplastic midface, growth deficiency throughout life, various joint abnormalities, a high frequency of cardiac defects, and hyperactivity.

Of more recent concern is that moderate, mild and/or binge drinking may cause mild or less obvious forms of

developmental damage. For this reason one can conceptualize the teratogenic effect of alcohol as a spectrum. That is, while heavy drinking may result in Fetal Alcohol Syndrome, lower levels of consumption may result in mild growth delay, mild lowering of learning potential and other subtle defects. Currently Fetal Alcohol Syndrome, is believed to be the second most frequent birth defect in the U.S. and the number one cause of mental retardation.

The Fetal Alcohol Syndrome Project of the Indian Health Service was conceived and established as a special project for the International Year of the Child. The Indian Children's Program of the Mental Health Branch of the Indian Health Service (IHS) convened a select committee of experts from various programs within IHS and it was decided to have a special initiative on Fetal Alcohol Syndrome. The experts from pediatrics, psychiatry, field clinics and other interests felt that Fetal Alcohol Syndrome was becoming a problem among some Indian tribes, but the exact nature and extent were unknown. Therefore a multifaceted plan was conceived which would approach it from a number of perspectives and answer a number of questions about Fetal Alcohol Syndrome.

As defined, the project was to accomplish a variety of objectives. Basically, training, treatment, and research were to be addressed.

Referral to the services of the project come from a variety of sources within Indian communities and are generally made through local IHS service providers at individual service units. Major coordination is through designated individuals at service units who have been extensively trained in the recognition of FAS and the services of our program. Whenever clinics are held they are "Developmental Clinics" where the end result is a variety of diagnoses in addition to FAS and alcohol related ones. All clinics are carried out by a dysmorphologist.

The current staff of the FAS project consists of four regular personnel and two consultants. The specific breakdown is as follows: Director, (Ph.D.), two Field Coordinators, (B.S. and A.A.), Secretary, and two consultant Dysmorphologists (pediatricians who specialize in birth defects and anomalies). All of the staff has extensive experience in Indian health care and/or is Indian. Extensive coordination with a variety of agencies is a vital part of the project. Only through extensive team work is the project possible.

At the present time the findings show great variation. In some service units and/or reservations no Fetal Alcohol Syndrome children have been found, while others seem to have severe problems. In general the pattern of FAS distribution is following the pattern of drinking described in the social science/epidemiological literature. That is, tribes with loose, band level social organization have a high incidence of alcohol damage; those with strict, highly structured tribal organization have fewer drinking mothers and a lower incidence of fetal alcohol damage. Other findings of interest are: approximately one third of the children seen in the special clinics are FAS which in-

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Increase your chances for a Healthy Baby



The sadness of Birth Defects



The Joy of a Healthy Baby

YOU CAN PREVENT A MAJOR BIRTH DEFECT, FETAL ALCOHOL SYNDROME.

Excessive Drinking of Beer, Wine, or Alcohol of any type during pregnancy can damage the Developing Baby for the rest of its Life

DON'T DRINK WHEN PREGNANT!!

POSTERS SUCH AS this one are part of the health materials distributed by the Fetal Alcohol Syndrome Project. The project also distributes pamphlets, films, a FAS bibliography, and a resource guide.

Now, About the Delay...

A number of readers have called our office recently to ask why they haven't received the *NIHB Health Reporter* in recent months. Unfortunately, because of a complicated contractual arrangement between NIHB, our printer, and the Government Printing Office, we have been unable to go to press since last September. We hope the matter has been resolved and that we will be able to resume our regular publishing schedule in February.

We have attempted to keep tribal leaders, health officials, the media, and other interested persons informed of important developments through press releases issued from this office. To save costs, these releases are distributed to only a small percentage of our newsletter mailing list. Persons interested in receiving these mailings should contact our office.

Finally, we wish to correct an error that appeared in our last issue. On page 4, in the section on Maternal and Child Health, the sentence reads: "There are now provisions for direct funding to tribes under this block grant." The sentence should have read: "There are *no* provisions..." We apologize for any misunderstanding that resulted from this mistake.

—The Editor

Preventive Medicine...

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which will provide free evaluation, health screening, and information on such health problems as high blood pressure, diabetes, arthritis, cancer, glaucoma and other eye problems, poison control, and environmental health.

Other conference activities will include a traditional Indian dance, an extensive exhibit display, a raffle, bingo, and an awards ceremony. Proceeds from these activities will be used to help offset the costs of speakers, facilitators, printed materials and other expenses related to the conference.

Exhibit space at the conference is available at the following rates: Commercial Exhibitors—\$400; Non-profit Organizations—\$300; Indian Non-profit Organizations—\$200; and Individual Indian Exhibitors—\$100. Application forms and additional information about the exhibits can be obtained from the NIHB central office.

Forms for conference registration and hotel reservations are provided in the center insert of this issue. Conference pre-registration is \$44, and registration at the conference site is \$48. Registration entitles participants to attend all conference general assemblies and workshops, receive conference information materials, and obtain one tape recording of a workshop or general assembly session. Registrants will also be eligible for door prizes to be given away during the conference. Pre-registration forms should be submitted no later than March 31, 1982.

The Tucson Community Center will be the site of conference activities, and a number of rooms at nearby hotels are being held at government rates for conference participants. Hotel information is included in the attached center insert. Housing arrangements should be made through: the National Indian Health Board Housing

Bureau, Attention: Lois Patterson; Tucson Convention and Visitor's Bureau; 120 West Broadway; Tucson, Ariz. 85701.

For additional information about the Fifth National Indian/Alaska Native Health Conference please contact the NIHB central office; 1602 S. Parker Rd., Suite 200, Denver, Colo. 80231. Phone: (303) 752-0931. ■

Pilot Program...

Continued from Pg. 11

icates appropriate referrals; the sex ratio of FAS children appears to be normal; a number of other birth defects (such as Downs Syndrome, Fetal Hydantoin Syndrome, Noonan's Syndrome, etc.) have been diagnosed and referred to treatment.

In addition, the few mothers who have produced FAS children appear to be extreme and chronically high-risk individuals in the social sense. Indicator's of this include: a high percentage of the FAS children are in foster placement; a high percentage of the mothers are deceased; one fifth of the mothers producing alcohol damaged children have produced more than one, and most have extensive clinic records for alcohol-related problems such as accidents, trauma, alcohol withdrawal, etc.

Educational materials including posters, pamphlets, a bibliography, a resource guide, and a training outline have been developed and are available for distribution to all IHS, tribal or other Indian programs. Also available on a loan basis are F.A.S. films, slides, and a Junior and Senior high F.A.S. Teacher's Curriculum. For further information or materials, please contact the F.A.S. Project, 2401-12th St. N.W., Albuquerque, New Mexico, 87102. ■

Alcohol and Pregnancy...

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fort to accumulate data on the incidence and prevalence of FAS. While this data is preliminary, it is nonetheless alarming. In 20 clinics held so far (as of October 15, 1981) 205 children were referred for evaluation of developmental abnormalities, and of these 45.8 percent were confirmed FAS or FAE while another 6.8 percent were "suspicious" or had some evidence of pre-natal alcohol damage. In other words, more than half of these babies had alcohol-related damage.

In terms of rates, it is estimated for the United States generally that one of every 750 newborns suffer from the full-blown case of FAS. For Indian people in the communities studied to date the figures are much worse. The data shows that FAS among these Indian people is one in 550 births but the prevalence of FAS ranges down to a frightening one in 60 births.

Because of the magnitude of the problem and the preventive and treatment services of this program, it is among the most valuable of the Indian Health Service and should be expanded rapidly. Unfortunately, because of budgetary constraints, this program's funding is in real danger of being slashed and it may be discontinued. I would urge all Indian people to insist that this not happen and that the program be expanded as rapidly as possible.

For further information on these statistics or on the program's research findings, contact: Fetal Alcohol Syndrome Project; Indian Children's Programs, 2401-12th St. NW, Albuquerque, N.M. 87102. ■

Cuts in Federal Programs May Spell 'Disaster' for Navajo Nation

*The impact of recent budget cuts on Indian health care services cannot be measured simply in terms of dollar reductions for IHS and tribal health programs. Cutbacks in other areas such as housing, job training, social services, agricultural assistance, and economic development have had a devastating cumulative effect on Indian reservations across the country, and ultimately impact the health and welfare of the entire Indian community. In the following article, William E. Schmidt examines the result of cutbacks to many federal programs on the Navajo Reservation, and how those cuts are affecting services to the Navajo people. Reprinted with permission from the **New York Times**.*

WINDOW ROCK, ARIZ.—The Navajos, the nation's largest tribe, say that they are facing "disaster" as a result of the recession and federal budget cuts, which are causing widespread unemployment and social problems among Indians across the nation.

"Everything we have gained over the past 20 years in our fight against poverty and disease on the reservation is at risk," said Peter MacDonald, chairman of the Navajo Tribal Council. "More and more people are without jobs or coming onto welfare, and we do not have the funds or the ability to put them back to work or meet their needs."

Mr. MacDonald will lead a delegation of Navajos to Washington to urge the Reagan Administration and Congress to restore money cut from programs that affect Indians.

In the last year, the number of unemployed on the desolate, starkly beautiful Navajo reservation here has nearly doubled, to more than 70 percent. According to some estimates, unemployment rates among Indians are generally running close to 40 percent, up 10 percentage points from a year ago, against a national average in November of 8.4 percent. In addition, the incidence of alcoholism, child abuse and other social problems has risen sharply.

All Tribes Are Troubled

The grim situation facing the Navajos reflects the broader economic malaise afflicting the nearly 700,000 Indians who live on reservations that are supervised and supported to a large degree by the federal government and that lack any viable private economy. According to the 1980 census, there are 1.4 million Indians living in the United States.

Among the poorest of the nation's minority groups, Indians on reservations say they have been especially hard-hit by Mr. Reagan's determination to cut spending.

"The reservation economy is dependent almost entirely on the federal structure and budget," said John Echohawk, head of the Native American Rights Fund, a national organization based in Boulder, Colo., that represents Indian legal interests. "The President wants to cut federal spending so the private sector can pick up the slack. But on the reservation, the federal government is the economy."

Since he took office, Mr. Reagan has insisted on a broad series of cuts in federal spending programs as part of his

plan for national economic recovery.

Mr. MacDonald, a Republican who backed Mr. Reagan in the election, said the Reagan Administration is not guilty of insensitivity toward Indians, but rather of a misperception of the effect the spending cutbacks would have. "When they talk about cuts nationally of 10 or 12 percent," Mr. MacDonald said, "they didn't realize that the impact is much greater, sometimes 50 percent or more, on the reservations which depend so heavily on these monies."

John McClaughry, a senior policy adviser at the White House, agreed that Indians are facing some unique problems. "Because they are such a small part of the population, with their own peculiar problems," Mr. McClaughry said, "it is easy for them to get lost in the shuffle." He said that Administration officials would be willing to review the effects of budget cuts on the Indians, though he could not promise any specific action.

Susan Shown Harjo, a lobbyist in Washington for the Native American rights group, said cutbacks in various Federal programs that serve Indians would total about \$500 million. These include funds for housing, education, health facilities, legal services and agricultural assistance.

Mrs. Harjo said that the cutbacks were making an already bad situation worse and that in some cases they may violate the terms of treaties by which the Federal Government is bound to provide for the education and welfare of Indians living on reservations.

Funds for Jobs Lost

Among the sharpest cuts were the loss of funds from the Economic Development Administration, which, tribal officials say, was providing money and jobs needed to plan and build private businesses on the reservation, as well as from the Comprehensive Employment and Training Act, which offered on-the-job training to unskilled Indians.

Navajo officials say they will lose \$130 million to \$150 million in state and federal assistance this year. In 1980, total aid to the reservation was about \$550 million.

The cuts affect a broad range of activities. For example, the Navajo Indian Health Service may lose \$5 million that was used to pay the salaries of ambulance drivers and community health representatives, who visit remote homes scattered across the 25,000 square-mile reservation.

Other cuts would remove what reservation officials say are critically needed funds for road and sanitary system improvements, as well as money for student scholarships and the construction of new schools.

Navajo welfare administrators said that over the last several months, the percentage of Navajo families living at or near the poverty level has grown to 87 percent from about 61 percent. For a family of four, the poverty level is an income of about \$10,000 a year or less.

"There is absolutely no way we can meet the need," said Bobby George, executive director of the Navajo Division of Social Welfare. He projected that the incidence of child

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Health Officials Still Waiting for Final Word on FY 1982 Budget

WASHINGTON, D.C. — With one-third of the current fiscal year already passed, Indian health programs are still faced with uncertainty over their funding levels for the remainder of the year.

Although the legislation that provides funding (the Interior Appropriations Act of 1982; P.L. 97-100) for the Indian Health Service was signed into law December 23, technical delays within the Administration have held up final budget decisions for a number of Indian health-related activities across the country.

The delay is the latest development in what so far has been a disastrous year for IHS and tribal health programs. Since the start of the current fiscal year October 1, most IHS facilities have operated at least 10 percent below their 1981 funding levels, while many tribally-administered programs have reportedly been struggling with even greater reductions.

On the Papago Reservation in Arizona, where the tribe administers disease control, nutrition, mental health, and other health services, budget constraints have resulted in severe cutbacks, particularly in the Community Health Representative (CHR) program, according to tribal health planner Sharmain Garcia. "We are in the process of having to re-examine the entire tribal health operation. We may have to consolidate or eliminate some services because the dollars are just not there," she said.

Tribal officials for the Navajo Division of Health Improvement Services (DHIS) have been forced to cut back such programs as emergency medical services (EMS), tuberculosis control, and social hygiene (VD examination). The EMS cuts are "a devastating blow to the program and places the emergency care for Navajo people in jeopardy," says tribal EMS manager Henry Wallace.

The Albuquerque Area Indian Health Board's otitis media project "really took it in the teeth" because of

funding reductions, says the project's technical coordinator, Fred Valdez. He explained that the project, which treats serious ear disorders often found in Indian children, serves several remote areas in New Mexico. Travel restrictions required by budget cuts have made it difficult for the project to reach Indian people in those locations, Valdez said.

Marilyn Benton, of the Lac Courte Oreilles tribe in Wisconsin, said that contract care services have been limited to emergencies and that the tribe's Community Health Representative (CHR) program has been cut more than 20 percent.

Budgetary problems have also hampered IHS clinical operations. At the annual meeting of the National Council of Clinical Directors (NCCD) in December, several IHS physicians voiced their concern over personnel shortages and indicated that doctors, nurses, and other staff in IHS clinics are often being overworked in order to maintain existing medical services. If such personnel shortages persist, in addition to other funding limitations, some IHS clinics will be forced to cut back their services, says NCCD Chairman Dr. Terry Sloan.

According to IHS Chief Medical Officer Dr. James Felson, IHS may have to "absorb" losses as high as \$50 million in its 1982 clinical services budget. Felson explained that while the actual dollar amounts for 1982 clinical services are close to last year's level, factors such as inflation, pay hikes, and other mandatory cost increases are not provided for in the budget.

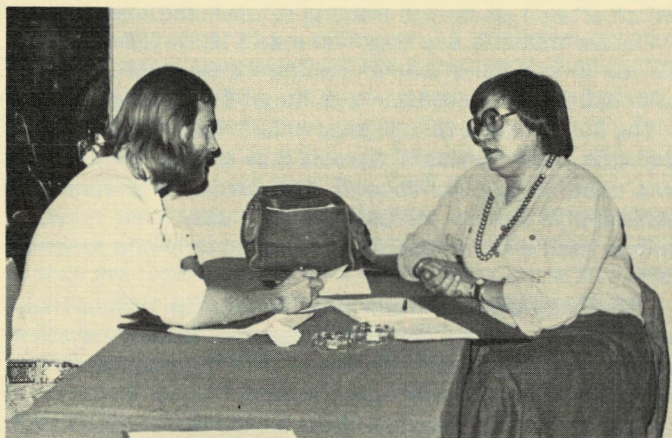
Tribes and IHS need to examine alternatives for providing health services with the reduced budget capabilities, he said. "We have to come up with about \$50 million in savings to provide clinical services at last year's level. Something is going to have to give in the system," Felson said.

He added that a task force has been formed within IHS to develop recommendations on how IHS can continue to provide services with the reduced 1982 resources. The group's report, which will be shared with tribes, should be completed by February, Felson said.

Problems with the funding cuts for FY 1982 were compounded by the inability of Congress and the Administration to enact the regular appropriations bills needed to finance the federal government, resulting in the passage of several "continuing resolutions" to provide temporary funding for most government agencies.

Additional fiscal constraints were placed on IHS November 10 when the Office of Management and Budget (OMB) issued a "deferral" notice to withhold \$10.95 million in IHS funds authorized by the continuing resolution. The deferral process permits the Administration to impound or withhold congressionally-approved funds for federal programs. The combination of the continuing resolution and the Administration's deferral action (the funds have since been released) required IHS to operate 10 percent below last year's budget.

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THE IMPACT OF federal budget cuts on IHS hospital and health clinic operations was one of the primary concerns addressed at the National Council of Clinical Directors meeting in Tucson, Ariz., in early December. Pictured above are Tim McQuinn, Clinical Director of the Pine Ridge Indian Hospital in South Dakota, and Eleanor Robertson, Aberdeen IHS Area Director, who both attended the meeting.

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For 1982, IHS has been appropriated \$599,645 million for health services and \$47,152 million for construction (see chart for estimated breakdown of this budget). Specific instructions for IHS funding will be made available to IHS area offices sometime in February, according to IHS officials. ■

**Comparison of IHS Budgets
for Fiscal Year 1981 and Fiscal Year 1982**
(in thousands)

IHS HEALTH SERVICES	FY 1981¹	FY 1981²
Clinical Services:		
Hospitals & Health Clinics	\$310,040	\$305,420 ³
Dental	17,692	17,884
Mental Health	7,513	7,488
Alcoholism	15,237	16,290
Maintenance & Repair	8,611	8,267
Contract Care	107,465	110,427
Equity Health Care	7,856	15,412 ⁴
Total, Clinical Services	474,414	481,188
Preventive Health:		
Sanitation	15,088	14,089
Public Health Nursing	8,006	7,969
Health Education	2,149	2,194
CHR's	36,304	28,800
Total, Preventive Health	61,547	53,052
Urban	8,900	8,160
Indian Health Manpower	5,808	5,760
Tribal Management	3,029	2,634
Program Management	53,011	48,851
Total, IHS Health Services	\$606,709	\$599,645
IHS CONSTRUCTION		
Hospitals, New & Replacement	25,693	9,531
Modernization & Repair	3,300	192
Outpatient Facilities	4,456	9,613
Sanitation	50,240	27,480
Personnel Quarters	780	336
Total, IHS Construction	\$ 84,469	\$ 47,152
TOTAL, IHS Budget	\$691,178	\$646,797

¹Includes FY 1981 Pay Act

²Excludes FY 1982 Pay Act of nearly \$18 million

³Reflects \$4.8 million for Medicare/Medicaid Reduction

⁴Includes \$2 million redistribution of FY 1981 base

(EDITOR'S NOTE: These figures represent only our estimations of the IHS budget. The official levels are still being calculated by IHS and may be slightly different than the ones shown here. Also, the FY 1982 figures are presented in this format to allow for a comparison with 1981 figures. This is different than the format used in the December 10 *Congressional Record*, which contained the IHS appropriations levels and was distributed widely among tribes. The different formats account for the apparent variations in the figures used here and those in the *Congressional Record*).

at no cost

Health Ed. Packages Available to Tribes

FORT COLLINS, COLO.—The National Indian Health Board Science Center is accepting applications from tribes and other Indian or Alaska Native organizations interested in receiving health education materials on infant feeding, diabetes, and traditional Indian foods. The materials—which are valued at \$50 per set—are being made available at no charge to tribal groups through a \$15,000 gift from Chevron U.S.A., Inc.

The three health education "packages," each of which includes tape recordings and illustrated booklets, are specifically designed for American Indian audiences. The materials can be used in Indian health clinics, Community Health Representative (CHR) programs, diabetes classes, elementary schools, child-birth classes, programs for the elderly, and other educational programs.

According to NIHB Science Center Director Alan Ackerman, the Chevron donation was made to help promote health education on Indian reservations. "Due to recent cutbacks in the federal budget, there is less time and fewer resources for health education," Ackerman said. "These packages have been specifically designed to provide health education at the patient level."

Tribes and Indian organizations interested in receiving the materials should submit a written request using the following guidelines:

—Tribal governments, health committees, CHR programs, and other Indian organizations can apply for any or all of the health education packages ("Infant Feeding," "Diabetes," and "Traditional Foods"), as their needs dictate.

—Written application must be made by an official of the tribe or Indian organization, specifying which materials are desired and how they will be used. Applicants must also agree to complete and return a simple evaluation form after using the materials. The request should be made on the organization's stationary, and should include a telephone number of a contact person.

—A maximum of three packages will be provided to any group as a gift. The NIHB Science Center reserves the right to select applicants to allow for a wide distribution of the information in these materials. Decisions of the Center are final.

—Under this program, only tribes or other Indian organizations are eligible; individuals are not eligible to be awarded these materials for their personal use, although the materials may be purchased from the NIHB Science Center. Tribes that have previously purchased the packages are not entitled to rebates, but they may apply for additional sets under this gift program. If any group needs more than the three sets offered through this program, they may be purchased for \$50 per set.

—The letter of application must be postmarked prior to April 1, 1982. Award notices will be mailed out April 15, and the materials will be distributed in late April.

For additional information, contact: Alan Ackerman or Suzanne King; NIHB Science Center; C/O Department of Food Science; Colorado State University; Fort Collins, Colo. 80523. ■

Cuts In...

Continued from Pg. 13

abuse would increase 10 to 15 percent over the winter and that alcoholism, already a major problem on the reservation, would increase markedly.

Ironically, despite the reservation's grim poverty, the Navajos sit atop billions of dollars worth of coal, gas and uranium deposits.

But among other things, the Navajos have been especially hard-hit by the slump in the uranium industry, where falling ore prices have resulted in the layoff of thousands of workers in the nation. Hundreds of Navajos have lost their jobs at the mines in northwestern New Mexico.

In addition, the Navajos say they have been unable to cash in on other mineral wealth because they are bound by long-term contracts with energy companies negotiated when prices were lower.

John R. Hunt, director of the Navajo Division of Labor, calculates that out of a potential work force of about 83,000, 59,800 men, women and teen-agers, just over half the reservation's population of 160,000, are now without work. He forecasts that the combination of cuts in federal funds and the decline in private sector economic activity could drive unemployment on the reservation to 80 percent next year.

Gains of the Past Wiped Out

According to Mr. MacDonald, unemployment on the reservation was calculated at 38 percent just a year and a half ago, which reflected a relative gain for the Navajos, given the reservation's long-term poverty.

"With people out of work, they are unable to pay for electricity," Mr. MacDonald said. "They cannot meet car payments or pay for gasoline. Given the isolation and remoteness of the reservation, this is bound to result in a deteriorating of health care and services."

The Navajo Reservation, which straddles the borders of New Mexico, Arizona and Utah, covers an area the size of

Virginia. The population is scattered throughout the remote region, which is tied together with a primitive road network that is mostly unpaved and frequently impassable in poor weather.

More than 55 percent of the homes do not have electricity, and 25 percent do not have running water.

Despite the grinding poverty, however, officials here say relative increases in socioeconomic status, as well as federally-financed improvements in water, sewer and sanitation networks, have improved the overall health of Indians on the reservation, where the incidence of tuberculosis, infant mortality and infectious disease have declined dramatically.

"But if some of these federal programs are withdrawn," warned Dr. John Porvaznik, acting director of the Indian Health Service on the Navajo reservation, "many of the problems we saw in the past, like infant mortality, will recur." ■

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