

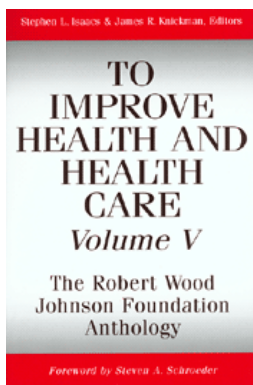
Programs to Improve the Health of Native Americans

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Robert Wood Johnson Foundation

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Over 100 years ago, the Indian people of this nation purchased the first pre-paid health care plan, a plan that was paid for by the cessation of millions of acres of land to the United States.

Senator Daniel Inouye¹

Editor's Introduction

The 2.5 million Native Americans living in the United States face significant health problems, including high rates of infant mortality, diabetes and alcoholism. Conquest and the resulting system of reservations characterized by poverty and hopelessness go far in explaining the compromised health of Native Americans, but many factors are at work.

Solutions to the health problems of Native Americans have been elusive. Since the 1800s, the United States government has had the obligation to provide health care services for American Indians. Before the 1950s, this obligation was characterized by extreme neglect, and worse. Even with the establishment of the Indian Health Service in 1955, resources have remained scarce.

Native American groups form sovereign nations and have their own beliefs and traditions. Programs designed to improve the health of Native Americans, if they are to be effective, must respect these beliefs and traditions and be culturally sensitive. With these precepts in mind, the Robert Wood Johnson Foundation funded two national programs to improve the health of American Indians.

In this chapter, Paul Brodeur, a veteran writer for *The New Yorker* and a frequent contributor to the *Anthology* series, examines these two programs. The first, Improving the Health of Native Americans, allowed grantees to develop projects addressing any type of health problem they chose.

The second, Healthy Nations, focused on substance abuse. Both programs gave tribes and Indian organizations wide latitude in developing strategies consistent with their own values.

This degree of flexibility was unusual for the Foundation. Even so, it has not always been easy to bridge the divide between a large, modern East Coast foundation and tribal groups having their own traditional approaches. The programs have raised a number of important issues, such as: How important is it to establish measurable goals? How can programs be evaluated objectively? Given the intractable social problems, what is an appropriate time period to look for results? How can a

foundation best develop capacity within the tribes so that something is left when the project ends?
Are programs like these simply drops in the bucket from a distant philanthropy?

These issues have implications beyond programs to improve the health of Native Americans. Indeed, they are relevant for any program where a donor is working across cultures with groups that have different outlooks, priorities and values.

In a 1985 report for the Robert Wood Johnson Foundation, Dr. Emery Johnson, director of the Indian Health Service between 1969 and 1981, wrote that "the pervasive powerlessness of Indian communities and their inhabitants, the long history of governmental suppression, discrimination, poverty, geographic and cultural isolation, lack of education and scarcity of employment are all major factors in the etiology of Indian alcoholism." Johnson's report, entitled "The Health of American Indians/Alaska Natives: Progress, Problems and Potential," provided the background for two national programs designed to improve the health of the Native American population: *Improving the Health of Native Americans* and *Healthy Nations: Reducing Substance Abuse Among Native Americans*.

As Johnson suggested in his report, the health of American Indians and the development of programs to improve it can be understood only in the context of their unique history of suppression and their cultural and geographical dislocation at the hands of the Europeans who settled North America. Nothing can undo such a history, of course, but thanks to an unprecedented apology that was delivered in the summer of 2000 by Kevin Gover, the director of the Department of the Interior's Bureau of Indian Affairs, the harsh mistreatment of the nation's indigenous peoples has become a matter of public and official record. In his apology, Gover said, "It must be acknowledged that the deliberate spread of disease, the decimation of the mighty buffalo herds, the use of the poison alcohol to destroy mind and body, and the cowardly killing of women and children made for tragedy on a scale so ghastly that it cannot be dismissed as merely the inevitable consequence of a clash of competing ways of life ... The trauma of shame, fear and anger has passed from one generation to the next, and manifests itself in the rampant alcoholism, drug abuse and domestic violence that plague Indian country."²

THE HEALTH OF NATIVE AMERICANS

The performance of the United States government in carrying out its obligations to protect the health of American Indians was marked by decades of gross neglect. By 1900, for example, the Bureau of Indian Affairs, which assumed responsibility for the health of Native Americans from the War Department in

1849, had only 83 physicians serving on Indian reservations; the first funding set aside specifically for Indian health—a mere \$40,000—did not come until a Congressional appropriation was passed in 1911. During the next 45 years, lack of adequate funding, as well as problems encountered in the recruitment and retention of physicians and other health professionals, continued to plague the Bureau of Indian Affairs.

In 1954, Congress passed a law providing for the transfer of all functions of the Secretary of the Interior relating to Indian health to the Surgeon General of the Public Health Service, or PHS. The transfer took place on July 1, 1955, when 2,500 health workers of the Bureau of Indian Affairs, together with the Bureau's 48 hospitals and 13 school infirmaries, came under the jurisdiction of the PHS's newly created Indian Health Service.³

Shortly after the transfer, the Indian Health Service found that "Indians of the United States today have health problems resembling in many respects those of the general population a generation ago." This was attributed to "inadequate health services, especially preventive health services, and to substandard and overcrowded housing and lack of sanitary facilities."⁴ Infant mortality among Indians was almost two and a half times that of the general population.⁵ Excess mortality among Indians was attributed "almost entirely to communicable diseases for which control measures are fairly well established, and to accidents, which are increasingly recognized as a public health problem." Among the diseases found to be responsible for this excess were tuberculosis, influenza, pneumonia and gastrointestinal diseases of dysentery, gastritis and enteritis.⁶ These accounted for approximately 25 percent of Indian deaths, but only about 8 percent of non-Indian deaths.⁷

During the next 30 years, the Indian Health Service implemented infectious disease control practices on Indian reservations. Tuberculosis and diarrheal dehydration—two major problems—were contained by early case finding, health education, the deployment of public health nurses, and, most important of all, by improving sanitation, which had been especially poor on most reservations.⁸ As a result of such initiatives, infant mortality decreased by 82 percent, the maternal death rate by 89 percent, mortality from tuberculosis by 96 percent, and mortality from diarrhea and dehydration by 93 percent.⁹ By 1985, tuberculosis—the fourth leading cause of death among Indians between 1951 and 1953—was no longer in the top ten; nor were gastritis, enteritis and colitis, which together had ranked number 7. Instead, chronic

diseases had become far more significant. Heart disease and cancers were among the top five causes of Indian mortality, as they were in the general population.

At the same time, diseases and causes of death in which human behavior was known to play a key role were increasing steeply. Accidents, homicide, suicide and chronic liver disease accounted for nearly one-third of Indian deaths, compared with less than 10 percent of deaths in the general population. Alcohol abuse was noted as a major factor.¹⁰ In fact, Indian death rates specifically attributed to alcoholism—deaths due to alcohol dependence, alcohol psychosis, chronic liver disease and cirrhosis—were found to consistently exceed the rate of all other United States races, reaching a peak of almost 10 times the all-races rate in 1971. In addition, Indian mortality from diabetes mellitus was more than double the all-races rate, and was steadily rising.¹¹

THE TENSION BETWEEN MODERN AND TRADITIONAL MEDICINE

Tension between modern and traditional medicine has been a recurring issue in addressing the health of American Indians. Under the leadership of Dr. James Ray Shaw, the first director of the Indian Health Service, tribal health committees were set up to try to bridge the gap between modern medical practices and traditional Indian healers, who had hitherto been banned from federal facilities.¹² During the 1960s, medicine men were found to be especially important in resolving mental health problems, and programs were instituted to develop working relationships between Indian Health Service mental health practitioners and Indian healers.¹³ These and other cooperative efforts continued under succeeding directors, and were a prime emphasis of Emery Johnson, the fourth director of the Indian Health Service. A passionate believer in Indian self-determination, Johnson dedicated himself to preparing the tribes to manage their own health affairs.

Johnson's efforts to gain self-determination for his Indian clients were also aided by President Richard Nixon, who, in a dramatic policy statement to Congress on July 8, 1970, ended the 1953 federal policy of tribal termination, under which tribes in selected states had been set free of all federal controls and support. Nixon's statement initiated a policy of Indian self-determination.

Early steps toward tribal control of health matters had been taken in the middle 1960s with programs financed by President Lyndon Johnson's Office of Economic Opportunity to deploy community health representatives, who were trained by the Indian Health Service in principles of health, sanitation, communication, first aid and home nursing. The impact of the community health representatives was

especially great on large, remote reservations, where, because the Indian residents lived in small and widely scattered communities, it was not feasible to send or station physicians and nurses.¹⁴

However, the most far-reaching step in attracting tribal involvement to resolve tribal health problems came with the passage of the Indian Health Care Improvement Act, in 1976. In this legislation, which authorized more than \$1 billion to supplement the regular Indian Health Service appropriation, Congress affirmed the "Federal Government's historical and unique relationship with, and resulting responsibility to, the American Indian people." Congress also declared that a "major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."¹⁵ The law stipulated that each tribe identify its own health needs and then design a comprehensive plan to meet those needs. This requirement was met by more than 90 percent of the 508 tribes that had by then been accorded tribal status by the Bureau of Indian Affairs, and were thus considered to be federally recognized tribes.¹⁶

The Indian Health Care Improvement Act was also designed to extend the services of the Indian Health Service to Indians living in urban areas. At the time of its passage, 1.2 million Indians were living in the United States, roughly half on reservations and half in cities—chief among them Minneapolis-St. Paul, Seattle and San Francisco. Because these urban Indians lacked education and job training, and because they were separated from their land and families, their condition was no better than that of their kinfolk who lived on reservations. Moreover, because Indians who left their reservations were no longer considered by the government to be Indians, urban Indians had been cut off from federal services specifically designated for American Indians, including health care.¹⁷

THE ROBERT WOOD JOHNSON FOUNDATION'S PROGRAM TO IMPROVE THE HEALTH OF AMERICAN INDIANS AND ALASKAN NATIVES

Emery Johnson noted in his 1985 report that there were five critical health areas affecting American Indians and Alaskan natives—alcoholism, diabetes, high infant mortality, child health problems and chronic diseases of the aged. He singled out the importance of alcohol abuse and noted that there had been many attempts—essentially undocumented—to prevent alcoholism among Indians through active intervention with Indian youth. "Examples include therapeutic recreation programs, sports, individual tutoring in schools to enhance individual self-worth, provision of active alternatives to the drinking society, and utilization of Indian culture and religion to provide a stable self-acceptance to avoid alcohol abuse," Johnson wrote. "Careful comparison of the factors involved in these attempts at prevention,

identification of those which seem to be related to a successful outcome, and design of prospective studies to validate successful interventions would appear promising."¹¹⁸

Based in part on Johnson's report, the Robert Wood Johnson Foundation launched, in October, 1988, a four-year program called Improving the Health of Native Americans by inviting Indian tribes and community organizations that serve them to submit proposals designed to prevent disease and injury, and to improve health care for Indian infants, children, adolescents and the elderly. Tribes and organizations submitting proposals were urged to focus on some of the major causes of mortality and morbidity among American Indians. The director of the Foundation's Improving the Health of Native Americans was Timothy Taylor, a member of the Kiowa Tribe, who was an assistant professor of health administration at the University of Oklahoma College of Public Health, in Oklahoma City. "What's unique about this initiative is that tribes are being given the opportunity to address their health needs from their own environment and perspective," Taylor said at the time. "The Foundation is encouraging Indian tribes to be imaginative and creative with their proposals."

During three grant award cycles between 1989 and 1991, the Robert Wood Johnson Foundation awarded \$6.2 million to 36 tribes and tribal agencies to begin health projects. (At the time, there were 515 federally recognized Indian tribes—318 in the lower 48 states and 197 in Alaska—and approximately 1.5 million people who identified themselves as Indian living in the nation.) The 36 tribes and agencies receiving grants were located from Maine to California, and from Alaska to North Carolina, and the approved projects dealt with a wide range of problems:

- The Aroostook Micmac Council, Inc., of Aroostook, Maine, undertook to reduce the level of child abuse and neglect among the Micmac with a program of education designed to break down a climate of denial.
- The Blackfeet Tribe of Montana attempted to reduce the incidence of domestic abuse on the Blackfeet Reservation in the north central part of the state by implementing educational programs designed to encourage batterers to discontinue their pattern of violence.
- Central Valley Indian Health—an organization serving Indians living in the Central Valley of California—sought to reduce the incidence of substance abuse among Indian adolescents with counseling sessions, and by holding community workshops that encouraged a return to traditional tribal values.
- The Ganado Unified School District No. 20 Foundation, in the Navajo Nation of northeast Arizona, developed and implemented a comprehensive program focusing on maternal and infant care.
- The Grand Traverse Band of Ottawa and Chippewa Indians, located in northwestern Michigan, undertook to prevent substance abuse within the family (with special emphasis on children) by

holding ceremonies and rituals of traditional spiritual and health practices, in order to renew selected customs and traditions of the tribe as they related to health promotion and wellness.

- The Maniilaq Association, an organization dedicated to fulfilling the health and social service needs of Native Americans living in northwest Alaska, started a project to reduce the incidence of children prenatally exposed to drugs, particularly alcohol, by seeking to empower Indian villages with the responsibility for their own health, well being and cultural survival.
- The Minnesota Safety Council, in St. Paul, implemented a program to reduce injuries and deaths from a high incidence of motor vehicle accidents, fires and falls among the Red Lake Band of Chippewa Indians in northern Minnesota.
- The St. Regis Mohawk Health Services, of northern New York, initiated a project to strengthen the parenting skills of young Indian mothers through mentoring, child care education and the inclusion of mothers and grandmothers in the provision of child health care.
- The Oneida Tribe of Indians of Wisconsin sought to reduce some of the precursors of heart disease and diabetes—specifically obesity and lack of activity among youth—by developing self esteem among sixth-to-eighth graders, instituting a weight control program providing basic nutrition and starting a fitness program that emphasized traditional tribal activities.

Some projects attempted to mesh the two worlds of traditional and modern medicine. The Navajo tribe of Arizona, New Mexico and Utah, for example, used both Navajo traditionalism and modern psychotherapy in the treatment of molested children in its project. The Navajo believe that if something evil happens to a person, he or she must have a ceremony performed in order to be rid of the evil and to restore a balance between the good and the bad. Psychotherapy alone is not considered to be sufficient to treat a sexually abused child, but must be used in conjunction with a ceremony performed by a Navajo medicine person to complete the healing process. The Navajo project also included an education program designed to prevent child sexual abuse.

In 1996, the Robert Wood Johnson Foundation awarded a grant to Lawrence R. Berger, a research scientist at the Lovelace Clinic Foundation, in Albuquerque, N.M., and a faculty member for the Indian Health Service's Injury Prevention Fellowship Program, to conduct a retrospective evaluation of all 36 projects that had been funded under the Improving the Health of Native Americans Program, and to prepare a monograph for Native American communities and program developers on promising models and practices. In his evaluation, which was delivered to the foundation in 1998, Berger found that Native American communities were "exploring solutions to health problems using strategies and methods rooted in their cultural, historical and spiritual heritage." Among the culturally based approaches to improving health were the use of sweat lodges—dome-shaped structures made from mounds of earth and willow poles covered with blankets or animal skins—which can accommodate ten or more people, who experience purification of mind, body and spirit by sitting in intense heat generated by pouring water

over hot coals in the center of the lodge, and by singing sacred songs, telling personal stories and participating in rituals such as the pipe ceremony. Other culturally based activities for improving health were group counseling sessions utilizing the traditional Talking Feather; storytelling by elders; participation in traditional crafts and singing, dancing and drumming; Indian language classes; pow-wows; discussion of historical and spiritual issues; recreational activities such as basketry, archery and canoeing; and intergenerational activities with young people participating in traditional teachings and ceremonies led by elders.

Not surprisingly, Berger found that an enormous challenge to incorporating cultural dimensions in urban programs was posed by the fact that client populations came from different tribes and had experienced different exposure to traditional ways. In addition, he learned that virtually every one of the 36 projects lacked a quantitative evaluation of outcome, and that except for the perceptions of community members, no hard data existed to demonstrate the effect of any given program on the community's health. Among the reasons for the paucity of evaluation data were a lack of follow-up of program participants, the perception by some tribal members that surveys of substance abuse were threatening, the confidential nature of traditional healing ceremonies, and the suspicion of Native American communities toward outsiders, including researchers. Berger also found a lack of objective consulting and technical assistance to tribes in the area of health services organization, financing and management. He recommended that in the future the blood alcohol levels in female Indian injury victims be reviewed, hospital records be examined to determine the incidence of fetal alcohol syndrome, and pre- and post-program surveys be conducted to measure self-esteem, decision-making, and leadership skills among young people and adults who participate in projects.¹⁹

In his monograph, entitled "Model Programs in Tribal Health," Berger reviewed ten projects that he considered to be outstanding. One of them was the development of a community clinic and wellness center by the Coeur d'Alene Tribe, of Plummer, Idaho. The tribe's goal was to establish a full-time clinic, known as the Benewah Medical Center, that would be tribally owned and managed and financially self-sustaining. In order to realize this goal, the tribe made several bold moves. Among them was the decision to serve both the Indian and non-Indian population of the area, to construct new health care facilities in phases dependent upon utilization and financial strength, to implement a financial system so that the clinic could become self-sufficient on the basis of third-party collections, to collaborate with the City of Plummer so that the Benewah Medical Center was eligible to apply for numerous outside sources of funding, and to hire a community outreach worker to help families fill out applications for assistance.

With 1,500 tribal members and 10,000 other people in its service area, the Benewah Medical Center had 8,000 registered patients by 1998. In July of that year, the Coeur d'Alene Tribe opened a 43,000-square-foot Wellness Center in Plummer, which houses a day-care program, community health services, a five-lane swimming pool, a therapy pool, a "healthy heart" snack bar, an aerobics area, wet and dry saunas, racquet ball courts, a strength-training area, a running track and a gymnasium.²⁰

Another model project cited by Dr. Berger was a motor vehicle safety program undertaken by the Navajo Nation, in Window Rock, Arizona, whose vehicle-related death rate was five times as large as that of the overall United States population. In 1988, the Navajo Nation Tribal Council decided to require the use of safety belts and infant car seats for all vehicle occupants. Cooperation for the project was established between the Navajo Department of Highway Safety, the local police and the New Mexico Traffic Safety Bureau. A Navajo medicine man delivered a blessing for the program on Navajo radio, which reaches an audience of 60,000 people. Navajo police established roadblocks, issuing citations, and explaining to drivers the importance of wearing seat belts and using car seats for their children. Within two years, adult seat belt use rose to more than 70 percent of motor vehicle occupants, and there was a 30 percent reduction in the rate of hospitalization caused by motor vehicle injuries.²¹

Still another project cited by Berger was conducted in Lawton, Oklahoma by Kenneth Coosewoon, a Kiowa/Comanche, who is both a sweat lodge leader and a certified alcohol and drug abuse counselor. Coosewoon believes that sweat lodges can play a major role in the prevention, treatment and aftercare of Indians with alcohol and substance abuse problems. "The sweat lodge is especially useful for individuals who are fearful of participating in any type of group work," he has said. "The process is extremely non-threatening, thereby allowing the participants to display more openness and a willingness to experience the physical and purifying effect." When Coosewoon conducts the lodge for people with substance abuse problems, he provides counseling and referrals. "The lodge is not a cure-all, it's a start," he has said. "It helps you get in touch with the Creator, to find and nurture the spiritual from within yourself. There is no membership or proselytizing, just the experience of the power of prayer. Once you get your spirituality, you can go to church, Alcoholics Anonymous, or other places." During the one-year grant period for this project, approximately 1,400 people attended the sweat lodges. Seven lodges were built to provide aftercare and follow-up services, 13 were used as alternatives to alcohol and drug use, and 5 were established in Oklahoma prisons, in which 22 percent of the inmates are Native American—nearly triple the percentage of Native Americans in the overall Oklahoma population.²²

THE HEALTHY NATIONS PROGRAM

By early autumn, 1992, funding for the Improving the Health of Native Americans program was coming to an end. At that point, having recently adopted a new goal area to reduce substance abuse and aware that a majority of grantees under the program had elected to focus on alcohol and substance abuse, the Robert Wood Johnson Foundation announced that it planned to award \$13.5 million for a new initiative called Healthy Nations: Reducing Substance Abuse Among Native Americans. Because the Foundation was already helping communities across the nation address the issue of substance abuse in its Fighting Back program, it decided to tailor a special initiative to Native American communities with a conceptual model similar to that of Fighting Back—a model that supported a broad engagement of the community in understanding the nature and extent of its substance abuse problem, as well as a process that would lead to a community-wide consensus on how to attack the problem. At the same time, Healthy Nations would incorporate, as did the Improving the Health of Native Americans program, traditional Indian cultural values into its substance abuse treatment projects.

Grants to finance the new program were to be awarded in two stages. During the first phase, up to 15 tribes and communities would receive two-year awards of as much as \$150,000 to plan and develop communitywide strategies to reduce the use of alcohol, tobacco and illegal drugs. During the second phase, the projects would be eligible for financing of as much as \$1 million over a four-year period to carry out the programs developed during the planning stage.

On December 17, 1993, the Foundation announced that 15 tribes and Native American organizations would receive financing for programs designed to combat alcoholism and substance abuse by addressing contributory problems, such as a deteriorating sense of cultural heritage, a lack of consistent opposition to substance abuse within individual communities, and strong peer pressure among youth to drink, smoke cigarettes and use illegal drugs. A wide variety of approaches was taken by the grantees. For example:

- The Confederated Salish and Kootenai Tribes of the Flathead Reservation, in Montana, undertook a media campaign to fight alcohol abuse that was operated by tribal young people.
- The Eastern Band of Cherokee Indians of North Carolina arranged for families to take in individuals who had come out of substance abuse treatment programs, thus providing them with a drug- and alcohol-free environment.
- The United Indian Health Services, in Trinidad, Calif., held a New Year's Eve Sobriety Pow-Wow, youth camp-outs and a traditional stick game tournament as part of its program to fight alcoholism and drug abuse.

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- The White Mountain Apache Tribe, in Arizona, formed a Men's Cluster group to address risk factors in the behavior of male substance abusers and to support non-drinking lifestyles.
 - The Cherokee Nation of Oklahoma held a Nativefest emphasizing the Tribe's cultural heritage and established a health program that emphasized walking and running. The program also trained 30 people to teach smoking cessation classes and sponsored community activities such as running clubs, youth/elder camps, native games, community dinners, and highway safety and wellness classes.
 - The Confederated Tribes of the Colville Reservation, in Washington, organized a Community Pride Ride featuring camping and horseback riding, as well as a sobriety and healthy choices pow-wow.
 - The Minneapolis American Indian Center sponsored a performance by the Dakota Plains Dancers that was attended by 800 young people, and began a comprehensive public awareness campaign to address alcohol, drug and tobacco abuse, using radio and television announcements, billboards, videos, brochures, posters, flyers and a quarterly newsletter.
 - The Friendship House Association of American Indians, in San Francisco, sponsored a traditional youth gathering attended by 350 young people and 80 volunteers.
 - The United Indian Health Services—by then based in Eureka, California—hired outreach workers to hold community events in remote townsites, some still without electricity, in order to bolster the morale of Indians living in outlying areas, who often had to deal with discrimination on the part of their white neighbors.
 - The White Mountain Apache in Arizona sponsored outings to sacred sites, a media campaign using radio and videos to promote parent/child communication, and a rope and obstacle course that was navigated by 500 young people.

In late November, 2000, this writer traveled to Denver and spent two days with Timothy D. Noe, who has been deputy director of the Healthy Nations National Program Office since 1998. A large, friendly and candid man, Noe is an expert in alcohol and drug abuse prevention, and, having visited all 15 grantees many times, is familiar with the programs operated by each of them. Early in our conversations, he pointed out that a great disparity in alcohol and substance abuse habits, as well as varying attitudes toward alcohol and substance abuse, exists from tribe to tribe. "The Southwestern tribes have one of the lowest cigarette-smoking rates in the United States, whereas the Plains Indians have one of the highest, so it wouldn't make much sense for Southwestern tribes to put a lot of resources into non-smoking campaigns," Noe said. "Moreover, some tribes have far higher drinking rates than others, so it makes sense for those tribes whose members are experiencing serious problems with alcohol addiction to place special emphasis upon dealing with alcoholism."

Noe went on to say that the drinking habits of some tribes were undoubtedly affected by the fact that certain reservations—for example, the Sioux Reservation at Pine Ridge, South Dakota—are close to towns that are filled with bars and package stores catering to Indians. Noe noted that drug abuse continues to be

a serious problem for American Indians. According to statistics released in July, 1998, by the federal Substance Abuse and Mental Health Services Administration, nearly 20 percent of Native Americans age 12 and older reported using illegal drugs, as compared to 11.9 percent for the total United States population.²³ The drug abuse problem among Indians is especially severe in urban areas with large Indian populations, such as Seattle, Minneapolis-St. Paul and San Francisco, perhaps a reflection of the distressing poverty that characterizes the urban Indian's lot. In 1990, the per capita income for the 23,000-member American Indian population of the Minneapolis-St. Paul metropolitan area was less than half that of whites, Indian unemployment was nearly 20 percent, and more than 60 percent of Indian children lived below the poverty line. In addition, nearly 75 percent of Indian families with children were headed by a single parent, Indian high school students had a dropout rate twice that of white students, and more than 30 percent of Indian people 25 years of age and older had not completed high school.²⁴

According to Noe, the Healthy Nations program has had to deal with drug abuse on a number of Indian reservations. "Not long ago, there was an epidemic of hepatitis C caused by the careless exchange of dirty needles among heroin-using members of one of the northwestern tribes," he said. "In order to combat the situation, the tribe's Healthy Nations project helped start a drug court, under which young people arrested for possession of illegal substances were not packed off to jail but were required to take part in a drug counseling program."

Following two days of discussions at the National Program Office, Noe and I flew to Tulsa, rented a car, and drove southeast about 50 miles on Highway 51 to the town of Tahlequah, headquarters for the Cherokee Nation Healthy Nations program, which serves the 65,000 Cherokee people living in the 14-county region of northeastern Oklahoma known as the Tribal Jurisdictional Area. There we visited for an hour with Lu McGraw, interim program director; June Maher, a health educator; and Ida Sue Grey, a public health educator, who described some of the projects that make up the Cherokee Healthy Nations program. Among these projects are safety and injury prevention education, a kindergarten-to-sixth-grade school health curriculum called The Great Body Shop, breast and cervical cancer education, running clubs, diabetes education, AIDS and HIV education, Indian heritage clubs, summer youth fitness camps, fetal alcohol syndrome education, smoking cessation courses and school wellness programs that have been instituted in 21 of the 100 schools in the Tribal Jurisdictional Area. As part of the school wellness programs, a registered dietician visits each school once a month to deliver a lesson to students on how to fix healthy snacks and meals, in the hope that it will encourage their parents to do the same.

ASSESSING THE HEALTHY NATIONS PROGRAM

From the outset, vast differences in cultural outlook and personal attitude, as well as the necessity of dealing with people living in large geographic areas, have made it difficult to apply orthodox standards in assessing the degree of success achieved by the recipients of Healthy Nations program grants. A good example of just how difficult can be found in a 1993 report written by Norman Dinges, professor of psychology and public policy at the University of Alaska, in Anchorage. The report attempted to evaluate the first two years of one tribe's Healthy Nations program, and was designed to answer questions about the nature of the alcohol and drug abuse initiative being instituted by the tribe, as well as the manner in which the goals of the initiative were being put into operation. In cooperation with the federal government and the reservation community, the tribal council had already established an alcohol abuse and prevention program that included alcoholic beverage control policies, school and community alcohol abuse and prevention education, outpatient counseling, and off-reservation inpatient alcohol abuse treatment. However, efforts to combat serious alcohol and substance abuse were fragmented, and only when the Healthy Nations program came into being were sufficient efforts made to mount a coordinated attack on the problem.

From the beginning, the Healthy Nations program functioned within the oversight of the tribal council and its chairman, the tribal health administrator and the tribal health and welfare committee. However, issues of territoriality arose when certain individuals felt left out of the program's planning and development process, when the program was seen as a potential competitor for limited budgetary resources, and when it was seen by some people as an indirect evaluation of the quality of previous efforts to combat alcohol and substance abuse. Issues of territoriality also arose when early Healthy Nations meetings were scheduled to be held in the tribal counseling center—the location of the Healthy Nations program office—and not in the tribal treatment and aftercare facility.

In his report, Dinges praised the Healthy Nations program by declaring, "Seldom if ever have the alcohol and substance abuse problems on the reservation been approached as a multifactoral problem in which all relevant agencies are working together to understand their part in the problem and their contribution to the solution." At the same time, he expressed uneasiness over the complex pattern of resistance to change that he had found on the part of many tribal members.

In September of 1997, Dinges submitted an analysis to the National Program Office of the Healthy Nations projects undertaken by three other Indian nations. He found that extensive political changes

within one tribe's health division had limited the number of tribal departments with which the Healthy Nations program could interact. He also found that as the primary facilitator of Healthy Nations links to the community, the tribal council required program coordinators to clear all advertising and press releases through its tribal public affairs office. Such constraints did not exist in the Healthy Nations programs of the other tribes.

One of the most interesting aspects of Dinges's report was his comparative analysis of group belief systems within the three grant recipients. A cardinal feature of the Healthy Nations program operated by one nation was that a coalition of people and agencies had formed a strategic alliance around the belief that their mission transcended individual aspirations. Among another, however, there was considerable disagreement over whether traditional tribal values and practices were the best way to reduce and prevent substance abuse, as well as conflicting beliefs about the problem among Healthy Nations program staff members, tribal administrators and members of the community at large. According to Dinges, no fewer than thirty different religious sects exist among this nation, ranging from Catholics and Lutherans to traditionalists, who hold puberty ceremonies that are considered to be pagan by some members of the tribe. For its part, the third nation had to contend with a diffuse and complex set of beliefs held by people living in the region regarding the reduction and prevention of substance abuse, including a widespread belief in native vulnerability to substance abuse.

In each of the years 1998, 1999 and 2000, Dinges submitted to the National Program Office Comparative Site Reports for the Healthy Nations programs operated by five Indian nations. Dinges's findings varied widely from program to program. For example, in his report of July 30, 2000, he found that identification and assessment of substance abusers was proving to be a major challenge for the Healthy Nations staff members of one tribe, who had not been trained for the task and had to rely on other tribal programs to carry out the function. In contrast, he reported that another tribe had developed a robust early identification and assessment program, and had provided alcohol and drug abuse education classes to 700 community members. In yet another program, he learned that although restrictions on the counseling roles of staff members had been lifted, referrals to other tribal agencies, even when there were indications of physical and sexual abuse, were not always acted upon.

Like Professor Dinges, Timothy Noe believes that an orthodox evaluation of the Healthy Nations program will be difficult. In order to be sensitive to Indian sovereignty, he says, the Robert Wood Johnson Foundation designed Healthy Nations to be planned and directed from within the Indian

community, with the result that no formal evaluations of the various projects were conducted while they were in progress. Recently, however, the Foundation awarded grants for formal assessment of the programs to Professor Dinges and to Philip May, professor of sociology and psychiatry, and director of the Center on Alcoholism, Substance Abuse and Addiction, at the University of New Mexico in Albuquerque. Dinges will conduct a systematic analysis of historical attempts to deal with alcoholism and substance abuse among the grantees prior to the Healthy Nations initiative, and will look in greater detail into the varying attitudes and responses of the grantees toward the problem. Professor May will conduct a statistical analysis of a series of indicators—accident investigations, alcohol- and drug-related arrests, clinic visits and such—to see if any trends can be observed. Their findings are expected to be ready in the autumn of 2003.

Meanwhile, Healthy Nations grantees are carrying out a range of interesting programs. The Seattle Indian Health Board under the leadership of director Steve Gallion has developed mentoring programs with the Boeing Corporation, Microsoft and the American Indian Academy of Science and Engineering. As a result of the Microsoft program, Indian youth are better prepared to participate in the company's High School Internship Program, which provides young men and women with the skills to be employed by Microsoft. Mike Goze, director of the Minnesota American Indian Association's Healthy Nations program, has instituted a large and well-attended recreational program, and has successfully expanded the mentoring project to include non-Indian mentors. Under the leadership of Wayne Grigsby, the Healthy Nations program of the Friendship House Association of American Indians in the San Francisco Bay Area has sponsored a comprehensive sports program, a traditional youth gathering, a parenting program, an after-school drop-in program, an annual youth conference and an annual celebration for families whose members are recovering from alcohol and substance abuse. Still another program has been operated by the United Indian Health Services, in Eureka, California. Its director, Jim McQuillen, who became a school board director in a northern California county that was notorious for discriminating against its Indian residents, managed to persuade his fellow board members to establish cultural sensitivity programs in their schools. The Eureka program also sponsors cultural awareness projects, after-school programs, youth counseling on substance abuse and appropriate sexual conduct, an Elders Conference, a Family Fun Day, Teen Advisory Groups and efforts to curb teenage smoking.

CONCLUSION

As the Healthy Nations program has drawn to a close, possible directions for future Foundation-sponsored initiatives have been suggested by the co-directors of the National Program Office—Spero

Manson, a Pembina Chippewa, who is professor and head of the Division of American Indian and Alaska Native Programs of the Department of Psychiatry at the University of Colorado Health Sciences Center, in Denver, as well as director of the University's National Center for American Indian and Alaska Native Mental Health Research Center, and Candace Fleming, who is an assistant professor in the Division of American Indian and Alaska Native Programs. One of their suggestions is that the Foundation make Native American communities aware of other Foundation programs for which they might be eligible to apply by establishing an office to educate Indian tribes about such programs, and to provide them with the necessary technical assistance to write grant proposals. (One conclusion to be drawn from the analysis of the Healthy Nations program is that most Indian tribes and communities lack the experience and training to write competitive grant proposals.)

A second suggestion, building on strategies that were employed by the Healthy Nations programs of the Cherokee Nation of Oklahoma, the Minneapolis American Indian Center, Northwest New Mexico Fighting Back, Friendship House Association of American Indians and the Cheyenne River Sioux, advocates culturally based recreational activities—such as horseback riding, lacrosse, running, dancing and sweat lodges—as vehicles for improving the physical and emotional health of Native American communities.

Manson and Fleming also suggest building leadership capacity for planning, programming and policy in American Indian and Alaska Native communities—something for which the Healthy Nations program has demonstrated a pressing need—and developing a mental health care initiative that would address the unique social, cultural, economic and geographic landscape of American Indian and Alaska Native communities.

As the cost of health care has risen, the inadequacy of government appropriations for Indian health has become increasingly evident. Some experts believe that the burden now being placed on Indian tribes to provide resources to supplement government appropriations accounts in large measure for the epidemic of casino gambling that has swept through Indian country in recent years, and that if the erosion of the federal role continues, the ultimate outcome may, in effect, become termination of federally designated Indian status in the nation.²⁵

Such an outcome would, of course, undo the long struggle of Native Americans to achieve true standing in their land of origin, as well as an undoing of the efforts of the Indian Health Service and of

foundations such as Robert Wood Johnson to improve the health of American Indians. It would also make a mockery of Senator Inouye's poignant reminder that more than a century ago the Indian residents of the United States purchased the first pre-paid health care plan in history by ceding millions of acres of land to the United States. Indeed, it would place Native Americans, who have been the victims of neglect and discrimination, in the unfair position of having to pay an exorbitant price for their health care plan not once but twice.

Notes

¹ A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "Political History of the Indian Health Services," *The Milbank Quarterly*, volume 77, number 4, 1999, p. 601.

² Remarks of K. Gover, Assistant Secretary for Indian Affairs, Department of the Interior, at the Ceremony Acknowledging the Establishment of the Bureau of Indian Affairs, September 8, 2000. <http://www.doi.gov/bia/as-ia/175gover.htm>.

³ A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "*Political History of the Indian Health Services*," *The Milbank Quarterly*, volume 77, number 4, 1999, p. 577.

⁴ E. A. Johnson, "The Health of American Indians/Alaskan Natives: Progress, Problems, Potential," unpublished report to the Robert Wood Johnson Foundation, 1985, p. 21.

⁵ *Ibid*, p. 26.

⁶ *Ibid*, p. 21.

⁷ *Ibid*, p. 23.

⁸ A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "*Political History of the Indian Health Services*," *The Milbank Quarterly*, volume 77, number 4, 1999, p. 580.

⁹ *Ibid*, p. 573.

¹⁰ E. A. Johnson, "The Health of American Indians/Alaskan Natives: Progress, Problems, Potential," unpublished report to the Robert Wood Johnson Foundation, 1985, pp. 25–26.

¹¹ *Ibid*, pp. 29–30.

¹² A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "Political History of the Indian Health Services," *The Milbank Quarterly*, volume 77, number 4, 1999, p. 581.

¹³ E. A. Johnson, "The Health of American Indians/Alaskan Natives: Progress, Problems, Potential," unpublished report to the Robert Wood Johnson Foundation, 1985, p. 56.

¹⁴ A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "Political History of the Indian Health Services," *The Milbank Quarterly*, volume 77, number 4, 1999, pp. 585–586.

¹⁵ *Ibid*, p. 591.

¹⁶ *Ibid*, p. 587.

¹⁷ *Ibid*, p. 592.

¹⁸ E. A. Johnson, "The Health of American Indians/Alaskan Natives: Progress, Problems, Potential," unpublished report to the Robert Wood Johnson Foundation, 1985, pp. 67–72.

¹⁹ L. R. Berger, *Improving the Health of Native Americans Grant Program: a Retrospective Evaluation*, unpublished report to the Robert Wood Johnson Foundation, 1998.

²⁰ L.R. Berger, *Model Programs in Tribal Health*, unpublished report to the Robert Wood Johnson Foundation, 1998, pp. 4–5.

²¹ *Ibid*, pp. 8–9.

²² *Ibid*, pp. 18–19.

²³ S. Kasllagher, *The NCADI Report*, October 29, 1998.

²⁴ J. R. Moran, *Minneapolis/St. Paul Healthy Nations Documentation Report*, unpublished report to the Robert Wood Johnson Foundation, February 15, 1995.

²⁵ A. B. Bergman, D. C. Grossman, A. M. Erdrich, et al., "Political History of the Indian Health Services," *The Milbank Quarterly*, volume 77, number 44, 1999, pp.600–601.