Health News & Notes

Northwest Portland Area Indian Health Board

April 2000 Issue

Julia Davis, NPAIHB Chair

Excerpts of Julia Davis' April 11, 2000 Testimony to the House Interior Appropriation Committee Regarding the Fiscal Year 2001 Indian Health Service Budget

I am Julia Davis of the Nez Perce tribe. I am on the Nez Perce Tribal Executive Committee and Chair of the Northwest Portland Area Indian Health Board. On behalf of the Board's 41 member tribes in Oregon, Washington and my state of Idaho, I thank you for the opportunity to testify today on the FY 2001 Indian Health Service Budget. In addition to my testimony, I am submitting the Northwest Portland Area Indian Health Board's 11th Annual IHS Budget Analysis and Recommendations for FY 2001. This analysis was reviewed and amended by Northwest Tribes in Portland, Oregon on March 8 of this year. It includes a report card evaluation of the President's proposed budget.

Before I get to the analysis and evaluation of the President's proposed budget, I want to thank this committee for its work over these past 8 years. These eight years have been difficult ones for the health programs funded by the Indian Health Service budget. The Congress and the President have been successful in eliminating annual budget deficits and are on their way to eliminating the National debt. Tribes have never argued against a financially sound United States Government. We both have a mutual interest in achieving that goal. Tribes have argued that too much of these savings came from underfunding the Indian Health Service.

Over these past 8 years the committee had the unfortunate task of delivering the message to tribes that their health care programs could not receive any additional funds to address the health care problems that affect our people in greater degree than the general population. In fact, the committee received 302b allocations that were so low that it could not even appropriate enough funding to keep pace with the financial resources lost to inflation. Our analysis estimates the loss at $1.2 billion since FY 1993. We believe the committee supported current services increases at a minimum and also supported focused increases for areas where a real impact could be made on our health problems. Unfortunately, from FY 1995 through FY 1999 the annual increases in the Interior Appropriations Committee Allocation were the third lowest of the 13 committees. There really was little the committee could do to fund our programs.

Unlike this committee, the Administration has had an uneven record over these years. It's hard to say which budget proposed by President Clinton was most disappointing, his FY 1995 budget that proposed budget cuts or the one submitted in FY1999 that proposed a less than 1% increase. We thought the first budget was simply a sign of lack of knowledge of our program needs, the FY 1999 budget we thought indicated a lack of candor and integrity, since by

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Health News and Notes is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to represent the tribes of Washington, Oregon and Idaho on health-related matters and to provide health-related technical assistance.

We welcome all comments and Indian health-related news items. Address to:

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NPAIHB Tribal Program Spotlight

The Swinomish Health Clinic

Swinomish Success

by Esther Gartner

The Swinomish Indian Tribal Community has successfully built two rather large structures this winter: a new spacious health clinic and a new Local and Wide Area Network for their tribal site. The new health facility sits across the street from their current dental clinic and was designed to reflect the dental building's architecture. The new clinic will significantly increase the space for treating patients and provide for added benefits such as a patient education room, a workout/physical therapy center and spa/shower facility.

The Tribe has also built, nearly from the ground up, a large Local Area Network encompassing nine buildings connected with fiber optic cable running on a Microsoft NT network. The Circle of Health project staff spent much time working with the Tribal health staff, Tom Roberts (their local LAN Administrator), GTE and the networking staff at Washington State Department of Information Services to design, build and implement a LAN and WAN solution that would allow tribal members throughout the Tribe to communicate both within the organization and with corresponding colleagues at the state and federal levels through newly installed technologies such as electronic mail systems and the Internet. The new health clinic was also outfitted with new PCs that would handle the Y2K date rollover and support the desired applications of their new LAN and WAN.

Congratulations to the Swinomish Tribe for tackling two big projects and being successful in both their endeavors to improve the quality of health care to their community members!!

Hanford Health Information Network Tribal Service Program Farewell Notes

by Martha Holliday

After more than six years of operation the Hanford Health Information Network (HHIN) is scheduled for closure. The Tribal Service Program that serves the nine tribes that are either downwind or upriver from the Hanford Nuclear Reservation has been in business since 1993. The project has had many changes since its inception, however the focus of the project has always been the tribal communities.

We have had a complete staff turnover since the beginning, but we have had some Tribal Advisory Board members who have been with us since the start and we appreciate their dedication. In the last year the project has been doing oral histories, a gratifying experience because it documents the lifestyle of our tribes and includes them in the history of Hanford. The project staff is very grateful to all those who participated and we regret that we cannot do more. We thank all of those who took the time to share their life experiences for future generations.

Please call if you would like more information on available resources related to Hanford or a list of publications. Our toll free line will close on May 15, 2000, at which time we will be doing our final close out activities. A final report will be done for our funding agency that will include lessons learned. It will be available at the Northwest Portland Area Indian Health Board.

Following is the content of a letter that was sent to people who are on our mailing list. It provides dates for getting materials and final closure dates.

Closing Letter to Individuals on the HHIN Mailing List

Regretfully, the Hanford Health Information Network (HHIN) is closing due to lack of federal funding. This came as a surprise to us since we had been re-authorized for two more years. But we were awarded only enough funds for part of this year. It has been a great privilege to serve you, and we are sorry for this short notice.

May 15, 2000, will be the last day that you can request information from HHIN. The staff will make every effort to process and catalog your donated materials in the time left. Contact the Archives at:
1-800-799-HHIA (4442)
or by e-mail at:
hhia@its.gonzaga.edu

- **Oral histories**: HHIN can no longer help you record your oral history to donate to the Archives. The Archives will accept oral history tapes until June 30, but may not be able to have them transcribed.
- **Archives Web site**: Gonzaga University will continue to make the Hanford Health Information Archives Web site available:
  http://www.hhia.org
  Also see the Radiation Health Effects Archives Web site at:
  http://www.rhea.org

Yes**, I want to continue receiving information about the Hanford Health Information Archives.**
Please add me to the mailing list for the Radiation Health Effects Archives:

Name:
_____

Address:
_____

City:
_____

State: _____ **Zip code**: _____
Telephone:
_____
(daytime)
_____
(evening)
Mail to:
Radiation Health Effects Archives
Gonzaga University, Foley Center Library
502 E. Boone Avenue
Spokane, WA 99258-0095
or phone: (509) 323-6525

-clip or photocopy and mail

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Hanford Health Information Network - Triba Service Program Tribal Advisory Board
Front row: *Moses Dick Squeochs, Yakama Nation; Albert Garrick, Coeur d'Alene; Josie Shatanana(succeeded by Preston Kinne), Kootenai; Jo Marie Tessman, Umatilla; Martha Holliday, NPAIHB; and Madeline Queahpama-Spino*
Back row: *David Ernst, Spokane; John Stanfill, Nez Perce; Deb Louie, Colville; and David Bonga, Kalispel*

Guide to the Northwest Portland Area Indian Health Board Resolution Process

by Ed Fox

Resolutions: An important mechanism for policymaking, housekeeping…

Northwest Portland Area Indian Health Board (NPAIHB) resolutions are often the building blocks of legislation or Congressional appropriations born from the ideas of tribal communities, expressed in these communities, and discussed at Board meetings or other Board sponsored activity. There are multiple examples of this happening: much of PL 638 (Compacting and Contracting/Self-Determination) legislation, annual Indian Health Service (IHS) appropriations, Epidemiology Centers, this year's IHS request for Registry and Patient Management System (RPMS) funding, the proposed elevation of the IHS director to assistant secretary of Health and Human Services (HHS) and our support for a new Indian Health Care Improvement Act.

NPAIHB resolutions do not stay with the Board alone. Well over half are 'carried' to the Affiliated Tribes of Northwest Indians (ATNI) meetings for review by the health committee, chaired by the NPAIHB chair, for its review and often recommended for passage by ATNI's member tribes. NPAIHB's Executive Director and Policy Analyst make the decision about which resolutions should be offered to ATNI. Well over 75% of ATNI's health resolutions passed over the past four years were first Board resolutions. ATNI sends all health resolutions to the National Congress of American Indians meetings held twice a year, a mid year meeting held in the summer and a fall annual meeting held in October/November of each year.

In summary, the Board's resolutions are sometimes used to establish the Board's position on important issues. It sounds simple, but realize most areas of IHS have no mechanism to establish an area-wide "position." Without a position, it is hard to tell Congress or anyone: We oppose, We want, We think, We believe, We're shocked, We agree…etc. Almost more important, our position is *legitimate* because tribal leadership has participated in its development at several opportunities, the Board meetings, ATNI, National Congress of American Indians (NCAI), and sometimes the National Indian Health Board (NIHB). In the Northwest one seldom hears heard a tribe voice its dissension from a Board or ATNI position even if they opposed it when it was adopted. Northwest tribes are widely admired for their ability to develop and support Northwest positions on key and sometimes controversial issues.

When do we need or desire a resolution?

Resolutions have many important purposes. The Board has passed resolutions to:

- Support or oppose legislation.
- Obtain approval from delegates to pursue funding opportunities.
- Obtain approval to discuss partnerships with other entities (e.g. foundations).
- Influence administrative actions by federal and state agencies.
- Amend our policies and procedures (establish a lobbying fund).
- Adopt a strategic plan.
- Approve a project's goals and activities.
- Recommend tribal participation in a health promotion or disease prevention activity.

How can I have a resolution considered by the Board?

Answer this question first: Is a resolution required or desirable to accomplish a goal? One can consult with the NPAIHB Policy Analyst or NPAIHB program directors to see if a resolution might be appropriate. The Executive Director has final say, but most are clearly appropriate or not. The Policy Analyst can also give practical advice, samples, and editing. It is important to consult with NPAIHB staff to determine when to offer a resolution and which committee should review the resolution. Committee support of a resolution strengthens the presentation of the resolution to the NPAIHB Delegates.

If I write a resolution do I need to be at the meeting when it is considered?

It is not a requirement, but it is important to have someone who is knowledgeable about your resolution and can adequately address questions that the Delegates may pose. Delegates do carefully consider the impacts of a resolution and will not pass a resolution if they are not fully informed. It is recommended that if the author is not able to attend the presentation of the resolution, he or she brief another NPAIHB representative on the resolution. For example, the Executive Director, Policy Analyst, a delegate, and best of all a delegate that is on a committee interested in the resolution.

Is there a limit on the number of resolutions that can be considered at a Board meeting?

No. However, as a practical matter, we cannot have an unlimited number of

Continued on page 6 (Resolution...)

National Health Observances: An Internet Resource to Aid in Event and Activity Planning

Website submitted by Esther Gartner

The National Health Information Center has compiled a listing of National Health Observances for the year 2000. This list is published on the Internet at:
http://nhic-nt.health.org/Pubs/2000healthobserv/2000glnce.htm

Excerpts from this site are included to assist in program event and activity planning:

Health observances are days, weeks, or months devoted to promoting particular health concerns.

This calendar lists selected health observances for 2000 in three ways: the calendar shows days and weeks, and both the text listings and the "At a Glance" sheet show monthly health observances as well.

THE YEAR 2000 NATIONAL HEALTH OBSERVANCES AT A GLANCE

Health professionals, teachers, community groups, and others can use these special times to sponsor health promotion events, stimulate awareness of health risks, or focus on disease prevention. Materials available from sponsoring organizations range from a single flyer to packets of promotional materials.

Information appearing in this document does not represent an endorsement by the Office of Disease Prevention and Health Promotion, which does not have any role in naming any national health observance day, week, or month.

For more information, please contact the sponsoring organization directly.

April

Alcohol Awareness Month, National Council on Alcoholism and Drug Dependence, Inc., (212) 206–6770
Cancer Control Month, American Cancer Society, (800) ACS–2345 or (800) 227-2345
Counseling Awareness Month, American Counseling Association, (703) 823–9800
National Autism Awareness Month, Autism Society of America, (800) 3–AUTISM
National Child Abuse Prevention Month, National Committee to Prevent Child Abuse, (312) 663–3520
National Occupational Therapy Month, The American Occupational Therapy Association, Inc., (301) 652–2682
National STD Awareness Month, American Social Health Association, (919) 361–8400
National Youth Sports Safety Month, National Youth Sports Safety Foundation, (617) 277–1171
Women's Eye Health and Safety Month, Prevent Blindness America, (800) 331–2020
April 16–23, 2000 **National Infants Immunization Week**, Centers for Disease Control and Prevention – National Immunization Program, (800) 232–2522
April 17–23, 2000 **National Minority Cancer Awareness Week**, Cancer Information Service, (800) 4–CANCER
April 16–22, 2000 **National Organ and Tissue Donor Awareness Week**, National Kidney Foundation, (800) 622–9010
April 29–30, 2000 **WalkAmerica**, March of Dimes Birth Defects Foundation, (914) 997–4573 x4617

May

Asthma and Allergy Awareness Month, Asthma and Allergy Foundation of America, (800) 7–ASTHMA
Better Hearing and Speech Month, American Speech-Language-Hearing Association, (800) 638–8255
Better Sleep Month, Better Sleep Council, (703) 683–8371
Breathe Easy Month, American Lung Association, (800) LUNG–USA
Correct Posture Month, American Chiropractic Association, (703) 276–8800
Hepatitis Awareness Month, Hepatitis Foundation International, (973) 239–1035
Huntington's Disease Awareness

Continued on page 14 (Observations...)

Legal Notes

by Leroy Wilder

Is it time for an insurance check-up? Has your health program expanded? Do you have new contracts? Has the law changed?

In the last newsletter, this space raised concerns about the Justice Department's narrow view of Federal Tort Claims Act (FTCA) insurance coverage for tribes and tribal leadership. This situation, perhaps, is a warning to Indian tribal health programs to take a close look at their entire insurance package. Tribal health programs engage in a variety of activities involving the general public that may or may not be covered by FTCA coverage. It might be discovered that a greater range of liability exposure exists than first thought. It certainly would not hurt to be sure.

In conducting a survey of insurance needs, it is important to remember that there are two fundamental purposes for insurance. First, insurance is intended to prevent the loss of program resources in the event that liability for harm to a third party is established. It is a means to purchase peace of mind. Second, an important, but perhaps less often considered, purpose for insurance is to protect the general public. It is a matter of good public policy to see that a source of compensation is available in the event someone is injured by the activities or negligence of a tribal program. A good insurance package will provide protection for the tribal program and for everyone involved in an amount adequate to meet the potential exposure to liability. The package should protect members of the public who may be harmed as a result of involvement with the program.

Tribal programs may rely to some degree on the defense of sovereign immunity to protect their resources. This defense may not be available in all circumstances to individual employees and contractors. It also is not good public policy to rely on sovereign immunity as a defense to liability for harm to members of the public. If insurance is available, the better approach is to protect the program resources and *the public* by buying coverage if the cost is reasonable.

An insurance company is authorized to raise any defense to liability available to its customers. It is also important, therefore, to see that any policy forbids the insurance company from raising the defense of sovereign immunity. If the company is allowed to raise this defense, there is no reason to buy insurance. The general public will not be served by this approach. Section 450f(c) of the Indian Self-Determination Act provides appropriate language to include in any policy. Basically, an insurance carrier should be prohibited from raising the defense of sovereign immunity up to the limits of the policy.

A good place for help with a check-up is the insurance industry. Although its job is to sell insurance, it also knows the types of coverage available, the costs, kinds of exposures, and what coverage may not be necessary. Legal counsel also should be consulted. Umbrella policies to fill in gaps in coverage should be looked into. In summary, every tribal health program should have an insurance program to protect itself, its administration and employees, and the people it serves.

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resolutions. People do get anxious to wrap up our meetings by noon the last day of the Board meeting.

Is there a deadline for resolutions?

The Board does not have a deadline for resolutions. Delegates vote on resolutions the last morning of the Board meeting. This is one of the final tasks of each board meeting. Delegates can offer a resolution right up to that part of the meeting.

There is a deadline for ATNI and NCAI (usually the second day of their conferences). It gets very hectic at the deadline hour (usually 8 p.m.) with tired people jockeying for laptop time and the use of the printers and copiers. A resolution from the 'floor' is always possible, but difficult to orchestrate—this is where a delegate asks special permission to propose a resolution.

Options to Resolutions:

Before deciding to utilize a resolution it would be wise to consider other options.

- Letter of Support: The Board can approve a letter of support for the projects of other organizations.
- The Board could actually circulate a letter for signature by Delegate rather than a resolution during a Board meeting. NIHB, NCAI, and ATNI often do this, but the Board seldom uses this approach since its resolution process is so well developed and a letter signed by the Executive Director has nearly the same effect.
- Issue Paper: The Policy Analyst can assist you in the preparation of an issue paper. These are usually one to four page papers on a specific issue that are distributed at the Board meeting or via the Board's weekly mail-out. An issue paper can be strictly informational and may not require a resolution. However, issue papers are often supported by a companion resolution to give them more force.
- Executive Permission: Are you really just seeking approval to do something that the Executive Director or the Executive Committee may be able to grant? Again the Policy Analyst, Executive Director, or Administrative Officer can give advice here.

Introducing the Indian Community Health Profile Project

by Tam Lutz

The Northwest Portland Area Indian Health Board (NPAIHB) would like to introduce a new project called the Indian Community Health Profile Project. This project is developing an instrument for assessing the overall health status of American Indian and Alaskan Native (AI/AN) communities nationwide.

The Indian Community Health Profile will consist of a user-friendly set of health status measures to assess a tribal community of 1000–5000 members. The instrument is intended to provide Indian communities with a feasible method of assessing their overall health status, and monitoring that health status over time. The Profile is based on the belief that health is created at the community level for American Indians and Alaskan Natives (AI/ANs). However, measures of health currently available to AI/ANs are applicable only at the regional and national levels. This Profile differs from previous sets of health status measures in several ways. First, it was specifically designed to be a proxy for overall health status rather than the usual collection of morbidity and mortality measures. Second, it covers multiple areas of health including not only medical conditions but also mental health, dental, educational, and social indicators. Third, because the Profile was designed to be useful and practical at the community level, it was NOT designed to generate standardized data to be reported to a central location. Finally, instead of trying to cover all the important measures of health, the Profile contains only 15 measures, which are indicators of health status in each of the domains of health. The Profile is only a model: It is recommended that communities implement each of the indicators, though they may decide to add, delete, or modify the indicators to meet their particular local needs.

The Indian Community Health Profile

Funded by the Indian Health Service for design and implementation in three to five pilot sites during the year 2000

- Uses a broad definition of health.
- Generates data useful and useable at the community level.
- Contains 15 recommended indicators which are sentinels of health status in each of the domains of health.
- Works within the context and interest of participating communities.
- Engages the community in a systematic approach to eliminating health disparities

Indian Community Health ProfileStaff

Project Director

Trula Breuninger, MPH
Project Director

The Northwest Tribal Epidemiology Center will administer the project. The Director is Trula Breuninger, MPH. Trula is an enrolled member of the Navajo Nation from Ganado, Arizona, and has worked in the field of public health and Indian health programs for over 15 years. She has a background in managing, planning, and evaluating health care systems. She has also served as a consultant in the area of research, program development, and planning.

Project Specialist

Project Specialist Tam Lutz, MPH, MHA, is an enrolled member of the Lummi Nation. Tam has worked in

Tam Lutz, MPH, MHA
Project Specialist

Indian health programs for the last five years. She has a background in quantitative and qualitative research, injury prevention, community development, health planning, health-related instruction, and community-based programs.

The Profile Project would like to hear from interested communities. If your community is interested in participating as a selected site for the Indian Community Health Profile, **please contact Trula Breuninger, Project Director at (503) 228-4185 or send a letter of interest at the following to the address:**

Indian Community Health Profile Project
Northwest Tribal Epidemiology Center
Northwest Portland Area Indian Health Board
527 SW Hall Street, Suite 300
Portland, OR 97201

NPAIHB Scrapbook...

Best Wishes to Alicia!

Alicia Carson, Regional Training Specialist for the Northwest Tribal Cancer Control Project and EpiCenter Alumnus, recently accepted a position with the Intertribal Council of Arizona. Congratulations, Alicia! We are going to miss you!

Kelly Gonzales (NPAIHB's California Project Specialist) shares good thoughts and wishes with Alicia to take with her to Arizona

One of many things that we will miss about Alicia is her extraordinary fashion sense about shoes! Here Alicia tries her hand at stick the heel on the shoe.

New Faces at the Board...

Don Head,
Project Assitant
HPEP/NTRP

Darias Barney,
Project Assistant
HHIN TSP & PRT

Madara Winters,
Project Assistant
NTCCP

Despite experiencing a traumatic car accident just a few weeks earlier, Cheryle Kennedy, NPAIHB Executive Director, attended the Quarterly Board Meeting! We were all glad to see you out and about and looking so well!

Janice Clements presents at the All-Tribes Meeting in Portland, Oregon, March 8-10, 2000.

What Clinicians Can Do to Promote Behavioral Change

By Ruth Jensen

The American Cancer Society (ACS) reports that all cancers caused by cigarette smoking and heavy use of alcohol could be prevented completely. ACS estimates that in 1999 about 173,000 cancer deaths are expected to be caused by tobacco use. This accounts for about one third of all cancer deaths. ACS notes that many cancers, which are related to a person's diet and level of physical activity, can also be prevented. Scientific evidence suggests that up to one-third of the 564,800 cancer deaths expected to occur in the U.S. this year are related to poor nutrition or insufficient physical activity.

Clinicians are instrumental in helping patients change behavior which will reduce risk of chronic diseases like cancer. In A Guide to Clinical Services, Williams and Wilkins state, "Empirical research and clinical experience yield certain principles that clinicians can use to induce behavior change among patients." They recommend the following strategies for patient education and counseling.

1. Develop a therapeutic alliance. Assist patients in acquiring the necessary attitudes and skills to succeed in their attempts [to change their behavior].
2. Counsel all patients. Make a concerted effort to respond to the educational needs of all your patients in ways appropriate to their age, race, sex, socioeconomic status, and interpersonal skills.
3. Ensure that patients understand the relationship between behavior and health. Bear in mind that knowledge is a necessary, but not a sufficient, stimulus for behavior change.
4. Work with patients to assess barriers to behavior change. Anticipating obstacles to behavior change is fundamental to effective patient education since patients often do not follow physicians' advice concerning medication use or lifestyle changes.
5. Gain commitment from patients to change. If patients do not agree that their behaviors are significantly related to health outcomes, attempts at patient education may be irrelevant.
6. Involve patients in selecting risk factors to change. Let patient need, patient preference, and your own assessment of relative importance to health dictate your recommendation of which risk factor to tackle first.
7. Use a combination of strategies. Educational efforts that integrate individual counseling, group classes, audiovisual aids, written materials, and community resources are far more effective than those employing only one single technique.
8. Design a behavior modification plan. Patient education should be oriented toward what patients should do, not merely what patients should know.
9. Monitor progress through follow-up contact. Reinforce successes through positive verbal feedback.
10. Involve office staff. Use the team approach to patient education.

For a copy of the webpage, call or write Ruth at (503) 228-4185, 527 SW Hall, Suite 300, Portland, Oregon 97201 or rjensen@npaihb.org

Al Evans, NPAIHB Finance Officer

Introducing the New NPAIHB Finance Officer

by Al Evans

Al Evans was born in Portland, Oregon and raised in the Salem area. He attended schools in Salem and graduated from West Linn High School in West Linn, Oregon. After high school, he enlisted in the U.S. Navy where he served extensive overseas service, including three tours of Vietnam duty.

After getting out of the service, he attended Portland State University earning a Bachelor's degree in Business Administration with a Certificate in Accounting. Professionally, he earned a CPA and CMA certificate. His work has been primarily in the non-profit area with over 15 years experience on the supervisor and controller level with over ten of those years working in tribal organizations.

When not working, he does volunteer work for a homeless shelter, builds model airplanes, and does family activities. He resides in Salem with his wife, Ione.

HIV Prevention Needs of Oregon's American Indian and Alaska Native Population

by Amanda Cross

In partnership with the Oregon Health Division and funded by an HIV prevention grant from the Centers for Disease Control and Prevention, the Multicultural HIV/AIDS Alliance of Oregon (MHAAO) initiated a comprehensive, community led assessment of the unmet HIV prevention needs of communities of color in this region. MHAAO subcontracted with the Northwest Portland Area Indian Health Board's (NPAIHB) Project Red Talon, the Board's HIV and sexually transmitted disease (STD) prevention program, to conduct the American Indian/Alaska Native (AI/AN) needs assessment. The goals of this study were to better understand the HIV prevention needs of AI/AN people living in the Northwest, and to create a basis for recommending improvements to HIV prevention programs that target this community in Oregon.

A multi-tribal advisory group provided input on study methods, survey design, and proposed data analysis. Self-administered surveys were used to assess the HIV knowledge base and beliefs of the AI/AN community, and to screen for interview volunteers. Advertising for participants over age 18 resulted in a varied sample of 311 survey respondents, 174 men and 137 women ranging in age from 18–70 years. Tribal contacts coordinated distribution of the survey.

The study focused on four groups through in-depth interviews: men who have sex with men, women at risk for HIV infection, injection drug users, and gay/bisexual young adults. Interviews explored risk related behavior and social influences. Data was analyzed by risk group, focusing on HIV knowledge base, use of prevention services, risk related behavior, and community and family support. Although each risk group had distinct issues and concerns, the following were consistent across risk groups:

- Participants reported that sexuality is a taboo topic among many American Indians, who place a high value on modesty and view sexuality as a person's private business. Participants noted that shame around sexuality renders the topic inappropriate for open discussion in the AI/AN community, except in humorous contexts.
- Participants reported a widespread myth in the AI/AN community that HIV/AIDS is a "white man's disease," which doesn't affect Indian people.
- Participants reported that substance use significantly decreases a person's likelihood of practicing harm reduction behaviors.

Risk group data focusing on the HIV knowledge base and use of prevention services by participants revealed that knowledge and service access varies according to group. American Indian men who have sex with men understood the risks (or lack thereof) connected with casual contact and various sexual behaviors, such as anal sex, but did not understand the lack of risk involved with public blood product, the window period for testing, or the efficacy of different types of condoms and personal lubricants against HIV. They also reported fears and perceptions that there was a lack of confidentiality at tribal health clinics.

Women at risk assigned appropriate levels of risk to most sexual activities, but were unaware of women's higher risk for infection during unprotected, heterosexual intercourse. Some were also confused about perinatal HIV. These women most frequently accessed HIV testing while addressing another health issue.

AI/AN injection drug user participants had limited HIV knowledge frequently received at treatment centers. Injection drug users understood high risk behavior but not casual contact risks, and were suspicious of risk reduction methods such as condoms and bleach. They reported that drug and alcohol treatment centers and needle exchanges were difficult to access and too few in number.

The few gay and bisexual youth in our sample easily accessed HIV prevention services and information, understood the risks involved in activities such as anal sex or needle sharing, but were confused about the risks involved in kissing and "making out" activities.

The study also yielded information about the risk behaviors of participants. The men who have sex with men who participated knew that condoms reduced the chances of sexual transmission of HIV, but for a variety of reasons (including alcohol or drug use) did not always use them. Women at risk reported infrequent condom use and were most influenced by the belief that partners were not high risk and by their partner's resistance to condom use. Injection drug using participants reported that they preferred to practice harm reduction techniques with syringes, when possible, and that needle sharing had become less socially acceptable. However, injection drug users respondents reported believing that sexual transmission of HIV was less likely than blood transmission and were significantly less concerned about practicing safer sex. Gay and bisexual youth interview respondents reported using condoms fairly consistently. They also reported that condoms are accepted as a "regular" part of sex.

This assessment also sought to

examine the perceptions of participants about community and family support and HIV. Men who have sex with men reported that they perceive a high degree of homophobia in Indian communities. Many respondents had not "come out" to their families, feared rejection, and felt that their culture and their lifestyle were incompatible. Those "out" had varying levels of family support. Conversely, Gay and bisexual youth interviewees had "come out" with their nuclear families and reported varying levels of support, but not outright rejection. Injection drug users felt stigmatized because of their addiction. Women at risk often felt concern for their children as a primary motivation for practicing safer behavior or utilizing prevention services.

The findings from this study were used to suggest recommendations to improve HIV prevention programs that target this community in Oregon. These recommendations urged prevention providers to:

- Develop and adopt HIV prevention strategies that utilize these American Indian/Alaska Native cultural strengths such as respect for elders, care protection of children and families, native pride, storytelling, and humor.
- Focus on AIDS as a family and community issue, rather than as an individual behavioral or risk group issue.
- Design and disseminate culturally relevant HIV prevention campaigns to appropriate agencies and programs.
- Create mechanisms to include HIV positive American Indians in prevention activities and peer outreach**.**
- Focus on the link between substance use/abuse and HIV, emphasizing the relationship between drug and alcohol use and increased risk behavior and decreased harm reduction.
- Train clinic workers in cultural competence, pre and post-test counseling, to discuss barriers to condom use, and to empower clients to practice harm reduction.
- Encourage the state to examine misclassification of American Indians in HIV epidemiological data and to improve HIV surveillance of the American Indian community.

Despite potential limitations that must be considered in examining the conclusions of this work, such as small sample sizes, representation from only a select number of tribes, and survey self-selection bias, there were important results from this study that merit further investigation. Results should be read with the understanding that this is one of the first studies of its kind and further research needs to be conducted to confirm or refute the descriptive information reported here. For a copy of the study report or further information, please contact Project Red Talon at the Board.

Hanford... Continued from page 3

Future of the Archives:
Additional federal and private funds are being sought to maintain the Hanford Health Information Archives as a continuing public resource. Gonzaga University, where the Archives is located, will house the Archives as a special collection for 18 months while funds are being sought. A separate not-for-profit organization, the Radiation Health Effects Archives (RHEA), was created to continue the Archives, but does not yet have funding. Until funding is secured, access to the Archives collections will be limited, and the Archives will not be able to accept new donated materials or to respond to individual questions or requests. To be on the list to receive further information, please fill out the coupon above and mail it to RHEA.

Mailing List

Since you are receiving this letter, you are on an HHIN or Archives mailing list. A federal law protects the confidentiality of Hanford-exposed persons who have contacted HHIN (including the Archives). The sponsoring state health agencies, the Northwest Portland Area Indian Health Board, and the Archives will keep the HHIN mailing lists for at least one year and will uphold HHIN's confidentiality procedures. (The Resource Center's national mailing list will be held as part of the Washington State Department of Health's HHIN list.) The mailing lists will not be updated, however. **please note**: If you wish to remove your name from HHIN's mailing list, please let us know as soon as possible but no later than May 15.

If a Hanford-related study or health project is interested in sending information to the people on these mailing lists in the future, it can apply to do so under the confidentiality procedures.

Final Mailing

We hope to send you one final mailing later this spring. This will include a last newsletter issue, and updates on key Hanford-related studies and public health activities.

On behalf of the Network's citizen advisory board members, staff, the Northwest Portland Area Indian Health Board , and the Agency for Toxic Substances and Disease Registry, thank you for your interest and support of the Network over the past seven years. We hope you found our services helpful in answering some of your questions about potential health effects and the radioactive releases from Hanford. It has been an honor to serve you. Please call us by May 15 if you have any last questions.

American Indian Leadership Sets Focus for the American Public Health Association

Press Release by Indian Health Service

The American Public Health Association has elected their first American Indian as President. Michael E. Bird, MSW, MPH, of Albuquerque, New Mexico, was elected President at the 127th Annual meeting last year. Bird, a Santo Domingo/San Juan Pueblo Indian, will serve as president-elect for one year and assume office as President in November 2000.

"It is an honor to be a part of such an outstanding organization that benefits American's everywhere," said Bird. "My particular focus will be to continue the initiatives in public health that have become a significant factor in advancing the nation's health such as the President's Initiative to eliminate racial and ethnic disparities in health and the goal of Healthy People 2010. I also want to introduce additional focus on the disparity of health status between American communities and populations that have a basis in access to care and behavioral choices." Bird currently is a Preventive Health Programs Director with the Indian Health Service, an agency of the Department of Health and Human Services, with the Santa Fe Public Health Service Indian Hospital in New Mexico.

"In addition to providing health care to American Indian and Alaska Native people," said Michael H. Trujillo, M.D., M.P.H., M.S., the Director of the Indian Health Service, "we also recognize our responsibility to be health leaders and advocates for public health on the national stage as well. Michael has been involved with Indian and public health issues for more than 20 years and has made a difference in the quality of care at the local delivery area and also has helped increase awareness at the national and congressional level. His leadership of the APHA will continue to build on his achievements and will help shape the future of Indian health and the health of our nation."

Bird has a Bachelor of Science degree in anthropology and a master of social work form the University of Utah, Salt Lake City. He earned his master's degree in public health from the University of California, Berkeley. Bird has worked in a variety of health activities including medical social work, substance abuse prevention, preventive services, and hospital program administration. Bird has been a member of the APHA for 14 years. He was chair of APHA's Executive Board from 1998 to 1999. He was the president of the New Mexico Public Health Association in 1992, participated in the U.S. PHS Primary Care Policy Fellowship in 1996, and was a board member of HealthNet New Mexico, the state's Medicare and Medicaid program, for six years.

Testimony...Continued from page 12

then the budget had been developed by a new tribal and administration budget formulation process. This committee, Northwest Tribes, and tribes nationwide worked hard to achieve a FY 1999 budget increase of 6.7%—a far cry from the President's proposed 1% increase. The battle we fought together in FY 1999 seems to have had an impact on the Administration. Last year President Clinton requested a 7.6% increase and this year's proposed 9.6% increase indicate a fuller understanding of our needs. Unfortunately, a new Administration begins next year, but we will begin the process anew.

The Indian Health Service Budget Formulation Process and the Level of Need Funded Workgroup have both established $7.5 billion as the approximate level of funding needed to meet the true health care needs of Indian people. This corroborates the long-held view that less than 50% of true need is funded by the Indian Health Service budget. The Northwest Portland Area Indian Health Board supports the analyses that documented this level of need.

FY 2001 has begun with a promising start: First, the President's proposed Budget for the Indian Health Service includes a $229 million increase. The Senate Budget Committee has proposed a Budget Resolution that assumes a $230 million increase. This year's proposed increase of nearly 10%, while generous relative to the increases of recent years for the IHS, is less than needed to accomplish the goals of the President, Congress and Tribes.

Services are Being Cut Due to Inadequate Funding

There is strong evidence that services are being cut due to inadequate funding. In FY 1999 the IHS deferred payment authorization for 84,085 recommended cases and denied 15,844 determined not

to be within medical priorities. These reported amounts **understate** the actual unmet need since many tribes no longer report deferred services because of the expense involved in reporting. Unfunded Catastrophic Health Emergency Fund cases increased to $10 million in FY 1999 and it is estimated that $15 million in unreported cases exist since Indian health programs do not report cases once they know the funding has been depleted during the fiscal year.

President Clinton's Health Disparities Initiative

It is significant that the President now recognizes that the Indian Health Service does not have enough resources to raise the health status of American Indians and Alaska Natives to the level of the general population. The Presidential commitment to eliminate racial and ethnic disparities by the year 2010 is supported by new funding for health education, prevention, and treatment services for minority populations in the overall FY 2001 budget and the Indian Health Service budget. These potential ***supplements*** to IHS funding are welcomed, as is the President's commitment to eliminate racial and ethnic disparities in health status. The recent decline in certain health indicators (pointed out in the IHS budget justification) for American Indians and Alaska Natives must not be allowed to continue.

Many expected that grants from agencies outside the Indian Health Service would be the primary source of funding for the President's Health Disparities Initiative. Few expected to see this year's Indian Health Service Budget contain more funding for health disparities than it does for mandatory spending increases. Fewer still thought mandatory cost increases would be the source of funding for the Health Disparities Initiative.

Unfortunately, the President's proposed FY 2001 IHS budget and this year's health disparities initiative ***does not supplement*** the FY 2001 budget, rather is takes increases needed for current services increases and applies them to the health disparities initiative. In mandatory cost increases is their first priority.

Once Again There is No Funding Increase for Population Growth

Tribes have long testified that resources must increase to compensate for population growth just as they must increase for actual inflation costs. No funding for population growth in any program activity was appropriated in FY 2000. Based on the Indian natural growth rate of 2.1%, a budget increase of over $44,730,000 was justified. From 1992 to 1994 Congress responded in a very positive way by providing additional funds to support population growth. There has been no additional funding to cover the population increase of approximately 13% between 1995 and 2000. In FY 2001 the Indian Health Service provides a reasonable estimate that $44,543,000 is required to fund new services needed for a population growing at the 2.1% rate.

Contract Health Services (CHS, Contract Care)

Contract care is the program most vulnerable to inflation pressures. Between FY 1992 and FY 2000 NPAIHB estimates that approximately one quarter of a billion dollars was lost to inflation in the CHS program nationally. Unfunded medical inflation alone exceeds approved increases by $183 million. When population growth is included, approximately $245 million in purchasing power has been lost.

$40 Million Funding Increase for Contract Support Costs

Contract support costs funds are required for tribes to successfully manage their own programs. It is estimated that an increase of about $100 million in contract support costs is needed to fully fund contract support costs. The President has proposed spending $268 million, a $40 million increase. An additional $60 million is needed to fully fund contract support costs. It seems reasonable to ask for $50 million in FY 2001. This would fund 50 per cent of need and be another incremental step toward full funding in the not too distant future.

Request for Additional Funds

The budget presented by the Northwest Portland Area Indian Health Board in its analysis preserves the present program and provides program increases that are responsive to the Indian Health Care Improvement Act. It proposes an 18.8% increase of $450 million that is necessary if the Indian Health Service budget is to achieve the needs-based level of $7.5 billion within the next ten years. I invite you to review our recommendations of what could be accomplished with $220 million above the President's request. For example, we once again propose increased funding for alternative financing for facilities construction.

Conclusion

In conclusion, I would again like to thank this committee for it steadfast attention to Indian health. Tribes have benefited from having a committee that has taken the time to learn about the health issues that affect our people. Northwest Tribes appreciate the work of their representatives from both sides of the aisle that sit on this committee, Representative George Nethercutt and appreciate the time and attention that they and their staff and the committee staff have given to ensure a fair budget is developed with the funds available. I know the hours have been long and we have crossed swords on occasion, but this year I feel we have turned the corner and may now begin to rebuild our programs. Let's go back to work, finish the appropriation before August and begin again next year to improve the health of Indian people.

Observations... continued from page 5

Month, Huntington's Disease Society of America, Inc., (800) 345–4372

National Arthritis Month, National Arthritis Foundation, (800) 283–7800

National Digestive Diseases Awareness Month, Digestive Disease National Coalition, (202) 544–7497

National High Blood Pressure Month, National Heart, Lung, and Blood Institute, (301) 592–8573

National Melanoma/Skin Cancer Detection and Prevention Month, American Academy of Dermatology, (847) 330–0230 x343

National Mental Health Month, National Mental Health Association, (800) 969–6642

National Neurofibromatosis Month, National Neurofibromatosis Foundation, (800) 323–7938

National Osteoporosis Prevention Month, National Osteoporosis Foundation, (202) 223–2226

National Sight-Saving Month, Prevent Blindness America, (800) 331–2020

National Stroke Awareness Month, National Stroke Association, (800) STR-OKES

National Teen Pregnancy Prevention Month, Advocates for Youth, (202) 347-5700

National Trauma Awareness Month, American Trauma Society, (800) 556–7890

Older Americans Month, Administration on Aging, (202)401–4541

Tuberous Sclerosis Awareness Month, National Tuberous Sclerosis Association, (800) 225–6872

May 3, 2000 **National Anxiety Disorders Screening Day**, National Mental Illness Screening Project, (718) 351–1717

May 6–13, 2000 **National SAFE KIDS Week**, National SAFE KIDS Campaign, (202) 662–0600

May 7, 2000 **Mother's Day Comes Early For Too Many of Our Nation's Teens**, The National Organization on Adolescent Pregnancy, Parenting and Prevention, (202) 293–8370

May 7–13, 2000 **National Suicide Awareness Week**, American Association of Suicidology, (202) 237–2280

May 8–14, 2000 **National Mental Health Counseling Week**, American Mental Health Counselors Association, (800) 326–2642

May 8–14, 2000 **Food Allergy Awareness Week**, Food Allergy Network, (703) 691-3179

May 9, 2000 **Childhood Depression Awareness Day**, National Mental Health Association, (800) 969–6642

May 14–20, 2000 **National Alcohol- and Other Drug-Related Birth Defects Week**, National Council on Alcoholism and Drug Dependence, Inc., (212) 206–6770

May 14–20, 2000 **National Stuttering Awareness Week**, Stuttering Foundation of America, (800) 992–9392

May 14–20, 2000 **National Running and Fitness Week**, American Running and Fitness Association, (301) 913–9517

May 14–21, 2000 **National Emergency Medical Services Week**, American College of Emergency Physicians, (202) 728–0610

May 17, 2000 **National Employee Health and Fitness Day**, National Association of Governor's Councils on Physical Fitness and Sports, (317) 237–5630

May 22–29, 2000 **Buckle Up America! Week**, Office of Occupant Protection National Highway Transportation Safety Administration, (202) 366–9550

May 25, 2000 **National Missing Children's Day**, Child Find of America, Inc., (800) IAM-LOST

May 31, 2000 **National Senior Health and Fitness Day**, Mature Market Resource Center, (800) 828–8225

June

Fireworks Safety Month (through July 4), Prevent Blindness America, (800) 331–2020

National Safety Month, American Society of Safety Engineers, (847) 699–2929

National Scleroderma Awareness Month, Scleroderma Foundation, (800) 722–HOPE

June 4–10, 2000 **National Aphasia Awareness Week**, National Aphasia Association, (800) 922–4622

June 4–10, 2000 **National Headache Awareness Week**, National Headache Foundation, (800) 843–2256

June 12–18, 2000 **National Men's Health Week**, National Men's Health Week, (610) 967–8620

June 25–July 1, 2000 **Helen Keller Deaf-Blind Awareness Week**, Helen Keller National Center, (516) 944–8900, x 325

June 28–July 5, 2000 **National Prevention of Eye Injuries Awareness Week**, United States Eye Injury Registry, United States Eye Injury Registry

July

Fireworks Safety Month (see June)

Hemochromatosis Screening AwarenessMonth, Hemochromatosis Foundation, (518) 489–0972

July 9–15, 2000 **National Therapeutic Recreation Week**, National Therapeutic Recreation Society, (703) 858–0784

January 2000 Resolutions

RESOLUTION #00-02-01 "Support for the NPAIHB Contract with the Kaiser Family Foundation to Develop & Facilitate Training & Technical Assistance on Management/Administration, Financing & Tribal/State Relations for Indian Health Programs"
RESOLUTION #00-02-02 "Support for NPAIHB Legislative Plan"
RESOLUTION #00-02-03 "Support for a Third TIIAP/TOP Proposal: "Circle of Health: Information Infrastructure for Northwest Tribes"
RESOLUTION #00-02-04 "Support of the Oregon Public Health Association 2000 Conference-Health Disparities: Real Causes & Real Solutions"
RESOLUTION#00-02-05 "Support for Enhancing the Collaborative Work with Washington Tribes by the Western Tobacco Prevention Project"
RESOLUTION #00-02-06 "Support of NPAIHB Providing Services to California Area IHS for Diabetes Data Improvement for California Area Tribes Grant"
RESOLUTION #00-02-07 "Support for National Cancer Institute for Surveillance, Epidemiology and End Results Registry Program"

Calendar of Events

Native Wellness & Men Conference
April 17-20, 2000
Location: Albuquerque, New Mexico
Contact: Same as University of Oklahoma listed earlier

NICWA: 18th Annual "Protecting Our Children" - National American Indian Conference
April 17-19, 2000
Location: Tucson, Arizona
Contact: Same as NICWA training listed earlier

NPAIHB Quarterly Board Meeting
April 18-20, 2000
Location: Spokane, Washington
Contact: Elaine Dado
Phone: (503) 228-4185

From Community-Campus Partnerships to Capitol Hill
April 29 - May 2, 2000
Location: Washington, D.C.
Contact: sarena@u.washington.edu

NPAIHB Diabetes Workshops in conjuction with the IHS Diabetes Regional Meeting
May 4-5, 2000
Location: Spokane, Washington
Contact: Melissa Bernard
Phone: (503) 228-4185

ATNI Mid-Year Conference
May 1-4, 2000
Location: Coeur d'Alene Inn, Coeur d'Alene, Idaho
Phone: (503) 241-0070

Native Wellness & Women Conference North
May 8-11, 2000
Location: Albuquerque, New Mexico
Contact: Same as University of Oklahoma listed earlier

NCAI Mid-Year Session
June 25-28, 2000
Location: Radisson Hotel, Juneau, Alaska
Contact: Same as NCAI Winter Session listed earlier

NPAIHB Quarterly Board Meeting
July 18-20, 2000
Location: Klamath Falls, Oregon
Contact: Same as NPAIHB April Quarterly Board Meeting

National Indian Council on Aging Elders Conference
August, 2000 (Dates to be announced)
Location: Deluth, Minnesota
Contact: Dave Baldridge
Phone: (505) 292-2001

Millennium Conference 2000: "To Honor the Child"
August 9-12, 2000
Location: Olympia Resort and Spa, Oconomowoc, WI
Website: www.nicwa.org

ATNI 4th Annual Conference
September 18-21, 2000
Location: Red Lion Inn, Pendleton, Oregon
Phone: (503) 241-0070

NPAIHB Quarterly Board Meeting
October 17-19, 2000
Location: To Be Announced
Contact: Same as NPAIHB April Quarterly Board Meeting

NCAI Annual Session
November 12-17, 2000
Location: Radisson Hotel, St. Paul, Minnesota
Contact: Same as NCAI Winter Session listed earlier

128th Annual American Public Health Association Meeting
November 12-16, 2000
Location: Boston, MA
Website: www.apha.org/meetings/

Northwest Portland Area Indian Health Board

Executive Committee Members

Julia Davis, Chair, Nez Perce Tribe
Pearl Capoeman Baller, Vice-Chair, Quinault Nation
Janice Clements, Treasurer, Warm Springs Tribe
Corrine Hicks, Sergeant-at-Arms, Klamath Tribe
Norma Peone, Secretary, Coeur d'Alene Tribe

Delegates

Wanda Johnson, Burns Paiute Tribe
Dan Gleason, Chehalis Tribe
Norma Peone, Coeur d'Alene Tribe
Colleen Cawston, Colville Tribe
Bev Seaman, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Ed Larsen, Grand Ronde Tribe
Vacant, Hoh Tribe
Cindy Lowe, Jamestown S'Klallam Tribe
Tina Gives, Kalispel Tribe
Corrine Hicks, Klamath Tribe
Velma Bahe, Kootenai Tribe
Rosi Francis, Lower Elwha S'Klallam Tribe
Vacant, Lummi Nation
Debbie Wachendorf, Makah Tribe
Donna Starr, Muckleshoot Tribe
Julia Davis, Nez Perce Nation
Midred Frazier, Nisqually Tribe
Sandra Joseph, Nooksack Tribe
Shane Warner, NW Band of Shoshoni Indians
Rose Purser, Port Gamble S'Klallam Tribe
Marguerite Edwards, Puyallup Tribe
Pearl Conlow, Quileute Tribe
Pearl Capoeman Baller, Quinault Nation
Billie Jo Settle, Samish Tribe
Norma Joseph, Sauk-Suiattle Tribe
Wesley Edmo, Shoshone-Bannock Tribes
Mary Fisher, Siletz Tribe
Marie Gouley, Skokomish Tribe
Tracy Kiefer, Spokane Tribe
Robert Whitener, Squaxin Island Tribe
Marlice DeLys, Stillaguamish Tribe
Robert Alexander, Suquamish Tribe
Susan Wilbur, Swinomish Tribe
Marie Zacouse, Tulalip Tribe
William Burke, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

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