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# Model Programs in Tribal Health

The Lovelace Clinic Foundation

LR. Berger

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# MODEL PROGRAMS IN TRIBAL HEALTH

A Report for the Robert Wood Johnson Foundation



Prepared by  
Lawrence R. Berger, MD, MPH

The Lovelace Clinic Foundation

June, 1998

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# INTRODUCTION

The uniqueness and diversity of Native American communities has important implications for their health and medical care. Their populations may be urban or rural, geographically dispersed or concentrated, relatively homogenous or very pluralistic, deeply traditional or very identified with mainstream American culture. Respect for this complexity, and for the importance of self-governance, were the fundamental principles underlying the Robert Wood Johnson Foundation's "Improving the Health of Native Americans" grant program.

Between 1989 and 1991, \$6 million was awarded to Tribes and non-profit organizations serving Tribes for health-related projects. All of the projects were designed and implemented by the Tribes themselves. "The program is believed to be the first commitment by a major foundation to work directly with Tribal governments," said Steven A. Schroeder, MD, President of the Robert Wood Johnson Foundation. "We're encouraged that Tribes are able to approach their health problems with

imagination and creativity—using traditional Indian methods of care, as well as modern medical technology."

This report contains summaries of ten of the 36 Tribal health projects funded by the Foundation. These projects addressed a variety of health issues:

- Financing medical services
- Domestic violence
- Motor vehicle injuries
- Children with special needs
- Substance abuse prevention
- Care for elders
- Inter-generational activities
- Healing through sweat lodges
- Maternal and child health

- Teenage pregnancy and parenting

Each summary provides an overview of the project, as well as several resources for Tribes to obtain more information. For projects where the key individuals are no longer working with the Tribe, individual contact information is not provided. Also, many of the Tribes supplemented their Foundation grant with funding and in-kind contributions from other sources.

The purpose of this report is to share some of the ideas and experiences of these innovative health programs with Tribes, agencies serving Tribes, and individuals with an interest in Native American health. Suggestions for designing, funding, and implementing future programs are offered in the conclusion of this report.

Your comments and suggestions about the report are most welcome. Please send them to Katherine Kraft, PhD, at the Robert Wood Johnson Foundation.

## ACKNOWLEDGMENTS

The author is very grateful to all the individuals from Tribes around the country who shared information about their programs. Also, many thoughtful comments were provided by persons involved in the original "Improving the Health of Native Americans" program, particularly Emery Johnson, Timothy Taylor, Tom Senter, and Michael Cook. Annie Lea Shuster's enthusiasm and encouragement helped launch this review.

The following individuals provided expert skills in the preparation of this report: Carol Baldwin (artwork), Cristina Olds (graphic design), and Katie Racette (editing).

Funding for the evaluation was provided by the Robert Wood Johnson Foundation under grant number 028994. The Project Officers were Marjorie Gutman and Katherine Kraft. A complementary grant was awarded by the Division of Alcohol and Substance Abuse, Indian Health Service for in-depth analysis of the alcohol-related projects.

*The purpose of this report is to share some of the ideas and experiences of these innovative health programs...*



# DEVELOPMENT OF A COMMUNITY CLINIC AND WELLNESS CENTER

Coeur d'Alene Tribe, Plummer, Idaho

In 1989, the Coeur d'Alene Tribe wanted to expand the level of medical services available to its 1,100 enrolled members. The Coeur d'Alene Reservation is located in a rural area designated as both a Primary Health Professional Shortage Area and a Medically Underserved Area with a 66 percent unemployment rate. The Indian Health Service (IHS) funded a small ambulatory care clinic for eligible Indian patients in Plummer, Idaho. Physician staffing of the three-day-per-week clinic was obtained through a contract with a nearby

*The Tribe's goal was to establish a full-time clinic that would be Tribally-owned and managed, and financially self-sustaining.*

private clinic. There were 2,000 annual clinic visits to providers in the private sector under the IHS "contract services" program. The Tribe's goal was to establish a full-time clinic that would be Tribally-owned and managed, and financially self-sustaining.



## APPROACH

To realize its goal, the Coeur d'Alene Tribe made several bold moves. They:

- decided to serve both the Indian and the non-Indian populations. The Indian Health Service would provide funds to underwrite care for Tribal members; fee-for-service medical care would be available to the remainder of the community;
- constructed new health care facilities in phases, so that construction was dependent on both utilization and financial strength;
- implemented a financial management and billing system so the clinic could become self-sufficient via third-party collections;
- protected clinic operations from undue political interference by chartering a Health Board, with its own by-laws and separate from the Tribal Council, to oversee clinic operations. The Clinic Director reports directly to the Board. The Tribal Council remains responsible for signing contracts.
- formed a collaboration with the City of

Plummer. The nine-member Health Board is made up of seven Tribal members and two non-Indian representatives nominated by the Plummer City Council. The Tribal/City partnership made the BMC eligible to apply for numerous sources of funding (such as from the Bureau of Primary Care), broadened the clinic's base of support in the community, and made it possible to greatly expand services;

- adopted a computerized system for clinical information to support health planning, justify funding requests, and monitor health care quality and utilization
- became the first clinic site in Idaho to have its own state-certified worker to screen patients for eligibility for public assistance programs such as food stamps, Medicaid, disability, cash assistance, and day care. The worker, a resident of Plummer, is a state employee whose salary comes from both state and federal sources; the clinic provides office space;
- hired a community outreach worker to help families fill out applications for assistance (SSI, Medicaid) and transport them to eligibility appointments. By maximizing third-party reimbursements, this position resulted in a net financial gain to the clinic.

Another key element in the success of this program has been the willingness and ability of the Tribe, the Benawah Health Board, and its talented Clinic Director, Mr. Gary Leva to secure project funding from many alternative sources. Many of these sources are not ones traditionally used by Indian Tribes. It is safe to say that this program has left few stones unturned in its quest to improve the health care of its community. The sources include:

- 1) The Bureau of Primary Care Community and Migrant Health Center Program;
- 2) IHS PL 93-638 contracting program for direct and contract care funds;
- 3) The Department of Housing and Urban Development's Community Development Block Grants;
- 4) Fee-for-service revenue from private paying insured patients, managed care patients, and Medicare and Medicaid patients;
- 5) BIA Indian Business Development grant;
- 6) Defrayment of substantial malpractice insurance costs due to coverage (as a program

receiving IHS funding) under the Federal Tort Claims Act;

- 7) Corporate support for specialized projects and items of equipment;
- 8) Private foundations, especially the Robert Wood Johnson Foundation and the M.J. Murdoch Charitable Trust. Foundation support was vital during the start-up of the program, to hire staff and create the new financial management system before third-party billings were a major source of revenue; and
- 9) Assumption of well-planned debt. The Board has funded construction and other projects by securing low-cost, tax-exempt loans from local banks under the Community Reinvestment Act. These loans are being amortized by the application of revenues from medical services provided to insured patients.

## RESULTS

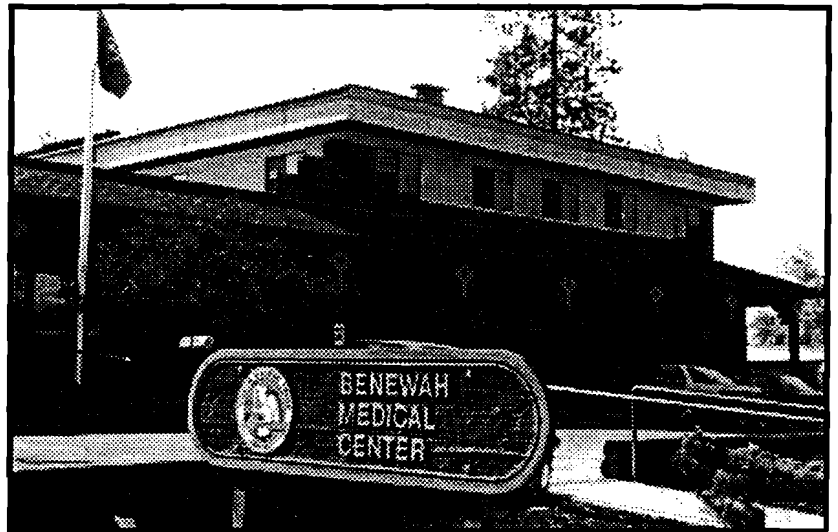
Dr. Neill Piland, a health economist who recently visited the Benewah Medical Center (BMC), described it as "one of the most innovative and successful community health partnerships yet undertaken in the United States." The BMC has become a community health system providing preventive, curative, rehabilitative, pharmacy, and behavioral services. With 1,500 Tribal members and an additional 10,000 people in its service area, the BMC now has over 8,000 registered patients. The clinical facility has grown from 800 square feet in 1989 to a modern, 18,000-square-foot structure in 1998. The number of staff has increased from 14 to 80.

The BMC enrolls 50-100 new patients every month. Third-party payments have increased by 20-30 percent each year. Whereas third-party billings accounted for only 2 percent of the medical center's budget in 1989, the current figure is over 30 percent (IHS funding through Tribal compacting accounts for the remaining 70 percent). Two million dollars for the Wellness Center was raised from third-party revenues accumulated over four years. The financial management system allows funding streams to be segregated so that non-Native care is not supported by IHS dollars; provides managed care companies with reports specific to their enrolled populations; and generates data to target priorities at the Wellness Center.

The community health services (CHS) component serves 60-75 patients on a regular basis for home health care and transportation to medical appointments. There is no charge to patients for

home services, although third-party sources are billed when available (IHS does not provide funding for home health care). CHS saves money by preventing acute illness in patients with chronic conditions and allowing earlier discharges from the hospital. CHS staff also work in the areas of maternal and child health, school health, nutrition, STDs, and environmental health.

A recent focus of the BMC is Tribal wellness, health promotion, and prevention. In July, 1998, the Tribe will open its 43,000-square-foot Wellness Center in Plummer. The center will house a day care program, community health services, conference center, five-lane swimming pool, therapy pool, "healthy heart" snack bar, aerobics and cardiac areas, wet and dry saunas, racquet ball courts,



a strength-training area, track, and gymnasium. Memberships will be available to non-Tribal residents. Prevention programs will be offered in weight management, diabetes prevention and control, parenting, childbirth education, and smoking cessation. Cardiac rehabilitation and physical therapy services are also planned.

## RESOURCES

Gary Leva, Director, Benewah Medical Center, PO Box 388, Plummer, Idaho 83851.

Andy Schneider and JoAnn Martinez: *Native Americans and Medicaid: Coverage and Financing Issues*. Report by The Center on Budget and Policy Priorities for the Kaiser Commission on the Future of Medicaid, Kaiser Family Foundation, 1997.

Stephen J. Kunitz: *The history and politics of US health care policy for American Indians and Alaskan Natives*. *American Journal of Public Health* 1996; 86:1464-1473.

# REDUCING FAMILY/DOMESTIC VIOLENCE

## Pine Ridge Reservation, South Dakota

Intimate partner violence is increasingly recognized as a serious problem throughout the United States, including Native American communities. On the Pine Ridge Reservation, court statistics revealed that nearly 70 percent of court activity was related to domestic violence. The vast size of the reservation, large numbers of people needing assistance, lack of referral resources, poverty, scarcity of adequate facilities to house victims, lack of transportation, shortages and high turnover of Tribal police, and the pervasiveness of violence toward women were some of the challenges faced by the program.

### APPROACH

The underlying theme was that violence is not a Lakota tradition. As Karen Artichoker, the project director, expressed it: "Violence was introduced into our communities by colonialism... Previously, women were respected and held as sacred within our communities. Violence against women and children was not the norm and was not acceptable. The goal of the project was to re-teach this and reintroduce this belief about respect for women and non-violence in our communities."

Developed jointly by the Oglala Sioux Tribe and the South Dakota Coalition Against Domestic Violence and Sexual Assault, this program emphasized both provision of direct services and community change. The program addressed the need to get the victims out of the violent situation and then work with the male offenders through counseling. Staff received referrals from the courts, interviewed offenders in jail, testified in court, performed assessments, and conducted follow-up by phone and home visits.

The objectives of the program were to:

- Increase community awareness and public education on the issue of domestic violence through community and school presentations, articles in the Lakota Times, and public service announcements (PSAs) on the local radio station;
- Provide intervention services, including a shelter and support groups, for adult and child victims to ensure their safety and empowerment. Women are informed about program services through direct mailings, posters, announcements in newspapers, and home visits by program staff.



- Educate and sensitize agency personnel (law enforcement, judges, prosecutors, chemical dependency and social work staff) to create an atmosphere of support and empowerment of victims of violence.
- Train Tribal police in order to improve their reporting and help them more effectively respond to victims and offenders;
- Provide direct services to violent men referred from the Oglala Sioux Tribal Court system. A Tribal ordinance mandates participation in education groups where individuals have the opportunity to "examine their behavior, make personal change, and re-enter the community as a new person." The program includes sweat lodges, "graduation" ceremonies for men completing the program, and recreational activities. The offender program was based on the Duluth Domestic Intervention Project, a nationally-recognized program developed by Marlin Mousseau, an Oglala Lakota man.

### RESULTS

The program, now called Cangleska, Inc., became a non-profit agency chartered by the Oglala Sioux Tribe. In 1997, the program received



he Marshall Peace Prize, the most prestigious award in the field of domestic violence. Program staff have become national trainers for the U.S. Department of Justice, conducting workshops for personnel from many Tribes.

Cangleska staff are the primary resource for training law enforcement personnel about the Tribe's mandatory arrest law and issues of domestic violence. The arrest and prosecution rate for offenders increased dramatically. There is now a dedicated court for domestic violence and a domestic violence probation department, with over 500 men on probation. A shelter that opened in 1997 is already too small.

Continuation funding was provided by Oglala Sioux Tribe Division of Health and Human Services, the Indian Child Welfare program of the BIA (emphasis on placement rather than violence reduction), a grant from the state of South Dakota, fines levied on the batterers, and grants from the federal Violence Against Women Act (VAWA) of 1994. VAWA required that 4 percent of the amount appropriated each fiscal year be allocated to Indian Tribal governments through a discretionary grants program. About \$1 million was available in FY 1995, with Tribes eligible to apply for grants up to \$75,000. Program staff participated in the national effort to obtain the Tribal set-aside. Cangleska's future plans include expanding services to child victims; implementing a school curriculum to assist students with problems related to domestic violence; and increasing prevention activities, such as making alcohol and drug treatment programs more available and creating a public service announcement for television.

Domestic violence creates daunting tasks, including ensuring the safety of victims through crisis intervention and shelters; empowering victims through medical, mental health, educational,

and social services; and conducting systems advocacy (to promote accountability and change institutional policies and procedures). The experiences at the Pine Ridge Reservation have much to offer Native and non-Native communities throughout the United States.

*Program staff have become national trainers for the U.S. Department of Justice, conducting workshops for personnel from many Tribes.*



## RESOURCES

Cangleska, Inc., P.O. Box 638, Kyle, SD 57714. A comprehensive, community intervention program, Cangleska, Inc. also offers community education and training for agency professional staff.

*Innovative Domestic Violence Programs in Health Care Settings.* Family Violence Prevention Fund, 1-888-RX-ABUSE. 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133. "The Fund's Health Resource Center on Domestic Violence acts as the nation's clearinghouse for information in this field."

Violence Against Women Office, Office of Justice Programs, 633 Indiana Avenue, NW, 4th floor, Washington, D.C. 20531 (Phone: 202-307-6026). Internet site at <http://www.usdoj.gov/vawo/> [www.usdoj.gov/vawo/](http://www.usdoj.gov/vawo/). National Domestic Violence Hotline at 1-800-799-SAFE (7233).

# MOTOR VEHICLE SAFETY

Navajo Nation, Window Rock, Arizona

Injuries are the second leading cause of death among American Indians and Alaskan Natives. Among the Navajo, the motor vehicle-related death rate was five times greater than for the overall U.S. population. Motor vehicle-related injuries were the second leading cause of hospitalization in Indian Health Service facilities. Yet in 1988, only 14 percent of Navajo adults were wearing seat belts and only seven percent of children were restrained in child safety seats.



## APPROACH

The Navajo Nation Tribal Council modified its motor vehicle safety code in 1988 to require use of safety belts and infant car seats for all vehicle occupants. The Navajo Office of Highway Safety then organized a comprehensive seat belt campaign to increase

*After two years, adult seat belt use rose to over 70 percent of motor vehicle occupants.*



public awareness of the law and the benefits of restraint use. The original objective was to increase use of motor vehicle occupant restraints to 50 percent. The program combined school-based education, public information, car seat loaner programs, incentives (such as T-shirts, bumper stickers, and "Saved-By-The-Belt" awards), and enforcement of the restraint law. It involved cooperation among the Navajo Department of Highway Safety, police, and social service programs; Indian Health Service; BIA Road Safety; New Mexico Traffic Safety Bureau; local businesses (which provided incentives and financial support); and other agencies and individuals.

There were educational programs for elementary through high schools, presentations at community chapter houses, meetings with judges, billboards, and radio spots in Navajo and English. A

campaign to increase public awareness of the law and the benefits of restraint use. The original objective was to increase use of motor vehicle occupant restraints to 50 percent. The program combined school-based education, public

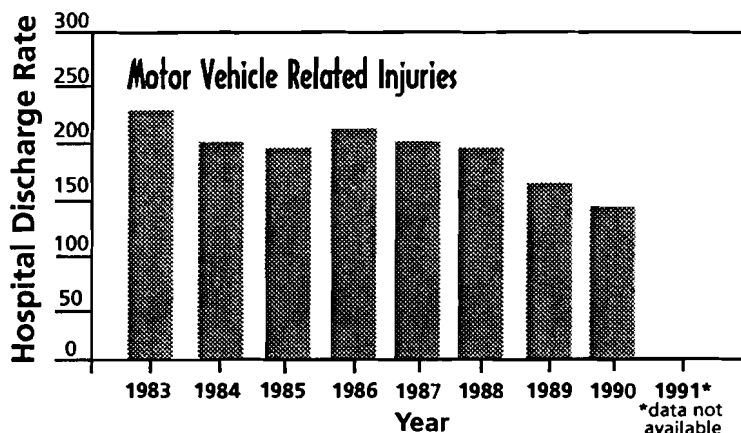
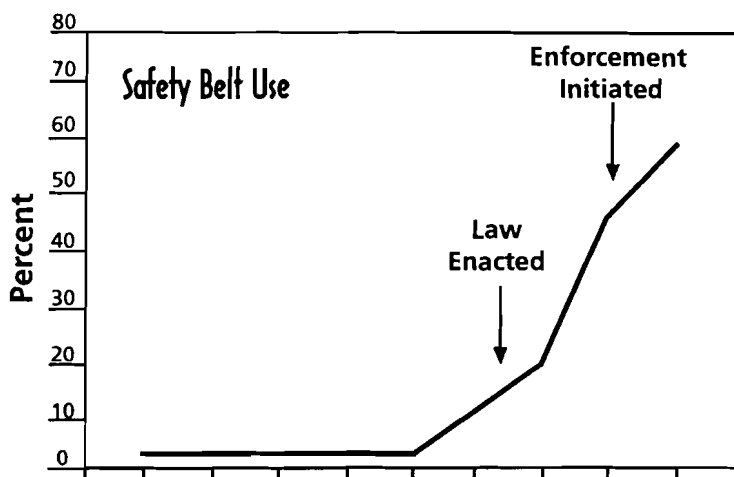
Navajo Medicine Man delivered a blessing for the program on Navajo radio, which reaches an audience of 60,000 people. A Navajo chapter of the National Safe Kids child safety program was established. A coloring book, "Let's Talk About Traffic Safety," was published featuring Navajo people, landscapes, and activities. In framing safety messages, care was taken to emphasize self-protection and caring for children and to avoid implying danger or mortality. The campaign was inter-generational: bilingual presentations addressed the older generation who relayed the safety messages to school age children who in turn relayed them to their parents. Hundreds of community health representatives (CHRs) were trained to discuss car seat use during their home visits with Navajo families. The "Saved-By-The-Belt" awards were especially popular among both families and the media. Individuals who were involved in crashes while using seat belts or car seats were honored and given awards such as new car safety seats. The resulting news stories depicted the honorees as positive role models for safe transportation.

After the public information campaign was well underway, Navajo police began to rigorously enforce the restraint laws, establishing roadblocks, issuing citations, and explaining to drivers the importance of wearing seat belts and using car seats for their children. Observational surveys of seat belt and child restraint use were conducted at both rural and urban sites on the Navajo Nation. Hospital discharge data was reviewed to determine the rate of motor-vehicle injuries before and after the campaign.

## RESULTS

After two years, adult seat belt use rose to over 70 percent of motor vehicle occupants. Seat belt use in Tribal vehicles was consistently over 90 percent. Child restraint use rose to 40 percent. There was a 30 percent reduction in the rate of hospitalizations due to motor vehicle-related injuries. (See graph at right.) The project was reported in the Center for Disease Control's Morbidity and Mortality Weekly Report (September 25, 1992) and in the "Cross My Heart" Seat Belt Campaign's Community Occupant Protection Resource Directory. The directory, a cooperative effort of the Indian Health Service and the National Highway Traffic Safety Association (NHTSA), was distributed to NHTSA regional offices, Tribal injury prevention committees, Indian law enforcement directors, Tribal chairpersons, BIA staff, Tribal health directors, Tribal highway safety coordinators, national Indian organizations, and state injury prevention offices. A video was also produced featuring the prevention efforts of the Navajo Nation.

Car seat loaner programs continue with Tribal, IHS, and state funding. Child passenger safety is now an established part of the Navajo CHR program. The Navajo program directors have provided consultation to other Tribes regarding enacting motor vehicle safety codes and promoting seat belt and car seat use. Injury prevention committees meet monthly. Lawrence Garnanez, project director and head of the Navajo Division of Highway Safety, described the Navajo Nation's efforts as "a model program in traffic safety." Nancy Bill, Navajo Area Indian Health Service Injury Control Specialist, noted that, "Every Navajo person's life has been touched by motor vehicle crashes — it's overwhelming. This program was the greatest achievement of all my work in public health."



## RESOURCES

Nancy Bill, MPH, Navajo Area IHS, PO Box 9020, Window Rock, AZ 86515.

Lawrence Garnanez, Navajo Division of Highway Safety, Window Rock, AZ 86515.

Richard Smith, IHS Injury Control Program Director, IHS/OEH-EHSB, 12300 Twinbrook Parkway, Suite 610, Rockville, MD, 20852.

*Safety-belt use and motor-vehicle-related injuries—Navajo Nation, 1988-1991.* Morbidity & Mortality Weekly Report 41(38):705-8, 1992 (September 25).

# IMPROVING CARE FOR CHILDREN WITH SPECIAL NEEDS

Southwest Communication Resources, Inc., Bernalillo, New Mexico

Families of children with disabilities or chronic illness face many challenges. One is the maze of providers and agencies offering medical, financial, and social services. Native American children in New Mexico are likely to receive services from IHS, Children's Medical Services (a state-funded program that provides diagnosis, treatment, and case management for certain medical conditions); the Bureau of Indian Affairs' special education program (which provides some therapeutic services to children meeting federal guidelines); and other nonprofit agencies, private practitioners, and school programs. The sheer number of interactions can be burdensome. So, too, can the other barriers to care, such as cultural insensitivity, lack of translators, medical jargon, and complicated financial procedures.

This project developed a model of interagency collaboration for the coordinated use of resources needed by Indian children and families. It also offered a program of parent education and support. The latter was based on the premise that parents can be more effective caregivers if they are supported by other parents and caring professionals within their communities.

## APPROACH

Southwest Community Resources, Inc., a nonprofit, community-based organization, developed this project in collaboration with parents, pediatricians, Tribal leaders, Head Start personnel, and other individuals from four Pueblo communities. The project sought to improve care for children and families through:

- Interagency Coordinating Councils
- Parent training workshops
- A resource directory of medical, social, educational, and financial services
- Family advocates offering case management and family support
- Training of providers in culturally-competent care
- Special Needs Registries
- Multi-disciplinary teams

The Interagency Coordinating Councils (ICCs) addressed bureaucratic procedures and jurisdictional issues. Federal, state, and Tribal agencies had overlapping missions but little formalized



communication. The ambitious goals of the ICCs were to develop consistent eligibility criteria and common procedures for intake across agencies, improve referrals and follow-up, eliminate duplication of services, coordinate existing services, identify gaps in services, and facilitate case management.

Family advocates were themselves parents of children with special needs. They received training in case management, communication skills, aspects of medical care of children with disabilities, and emotional support of families. Their job was to provide parent support and education, improved care through partnerships with health professionals, transportation, and patient advocacy. They made home visits, accompanied children and their parents to appointments, and attended case management meetings at schools, agencies, and medical clinics.

The Special Needs Registries were computerized databases to improve case management and service coordination by tracking information on children with chronic conditions. Building on existing IHS information systems, the registries organized diagnostic, treatment, and family information at the community level. The software was developed by an IHS epidemiologist (Dr. Roger Gollub), IHS pediatricians, and the Centers for Disease Control.

## RESULTS

The ICCs were successful in several areas. When children with disabilities entered elemen-

tary school, for example, collaboration was possible among Tribal Head Start, IHS, and the schools to make for a smooth transition. The ICCs developed common procedures to simplify intake for families into multiple programs. A feedback form was created to notify physicians on what action had been taken after a referral to another provider or agency.

In addition to providing direct services, the family advocates served as role models for parents. Assertiveness and advocacy, so important to obtaining necessary services, is not a cultural norm for many Indian parents. The advocates also helped sensitize health professionals to important cultural issues. (See table at right.) For example, a family member other than the parent may take the role of family spokesperson. In this event, a physician who directs his or her questions only to the parent will miss important information and the family will leave dissatisfied.

The computerized pediatric special needs registry organized complicated case summaries and care plans for children, and helped track their medical care, home visits, and referrals. A helpful spin-off of the system was that accurate data on the prevalence of pediatric chronic conditions could be reported to the state Department of Health. This data justified increased state funding of programs for children in Indian communities, including the use of Medicaid funds for case management services.

Many of the elements of the program were replicated in a project for urban Indian children. Helping Indian Children of Albuquerque (HICA) is a five-year project to provide service coordination to Native American children with special needs living in urban Albuquerque. Program staff visit families at their homes, accompany them to appointments, attend school meetings, and provide additional assistance as needed. A training program teaches parents how to be effective advocates for their children. The care coordinator ensures that appointments are kept and non-medical needs of the child and family are being met. Funding is from the federal Maternal Child Health Bureau, American Academy of Pediatrics, and Levi Strauss Corporation.

## RESOURCES

Norm Segel, Southwest Communication Resources (SCR), PO Box 788, Bernalillo, NM 87004 (505/867-3396)

Malach, R; Segel, N; and Thomas, T: *Overcoming*

*obstacles and improving outcomes: Early intervention services for Indian children with special needs.* Available from SCR.

Videotapes: *Listen with Respect, Finding the Balance:* Indian parents describe their experiences and frustrations as parents of children with disabilities, including cross-cultural barriers when using western medical services. Available from SCR.

Helping Indian Children of Albuquerque (HICA) Program, All Indian Pueblo Council, 3939 San Pedro NE, Suite D, Albuquerque, NM 87190.

Newacheck, PW; Stein, REK; Walker, DK; et al: *Monitoring and evaluating managed care for children with chronic illnesses and disabilities.* Pediatrics 1996; 98:952-958.A

Brewer, EJ; McPherson, M; Magrab, PR; Hutchins, VL: *Family-centered, community-based, coordinated care for children with special health care needs.* Pediatrics 1989; 83(6): 1055-1060.

COMPARISON OF HEALTH CARE PERSPECTIVES	
<u>"Western" System</u>	<u>Other Cultures</u>
Family includes biological parents and children.	Family includes extended family and community.
The relationship of family members determines their responsibilities.	The family or community determines family member responsibilities.
Education is highly respected.	Age and life experience mean more than years of education.
Health is viewed in terms of parts of the body.	Health is viewed as a combined state of physical, mental, and spiritual well-being which cannot be separated.
Ill-health is ascribed to infections, genetics, or environmental factors.	Ill-health may be caused by spiritual forces, imbalances of mind/body/spirit, or other factors.
Treatment is provided to the individual by a specialist who treats the specific ailment.	Treatment is provided to the "total" person and the person's family.
Western therapies (pharmaceuticals, surgery) are the exclusive approach to treatment.	Traditional therapies (herbs, ceremonies) are often considered in addition to, or in place of, Western therapies.
Asking questions and making eye contact show interest, attention, and respect.	Asking questions and making eye contact are considered disrespectful.
Silence during conversation is uncomfortable and may mean lack of knowledge, interest, or attention.	Silence during conversation is appropriate and signifies time for thought.
Time is short; seize the moment.	Time is plentiful; time should be taken to build trust and make the right decision.

*(Adapted from Southwest Communications Resources, 1993.)*

# CULTURAL CURRICULUM TO REDUCE ALCOHOL AND SUBSTANCE ABUSE

Institute for American Indian Arts, Santa Fe, New Mexico

"I have been impressed with the tremendous talent, with the richness of Indian cultures, and with the great knowledge and wisdom of Indian people. But Indian people are grieving the losses they have suffered over the years—loss of traditional lands; loss of the right to practice their religions, their culture, their traditions; and losses of thousands upon thousands of lives. Given the poverty and social deprivation associated with the high unemployment in Indian country, it should not surprise us that the lives of American Indian and Alaska Native adolescents are filled with stress."

— Daniel Inouye, Chairman of the Senate Select Committee on Indian Affairs, 1993.

In 1991, The Institute for American Indian Arts (IAIA) implemented an elective curriculum entitled, "The Natural Connection." The goal was to reduce alcohol and substance abuse among stu-

*During both of my two  
sweats I had break-  
through experiences in  
healing my soul and  
mind...*



urban settings and had little knowledge of their Tribe's culture or traditional ways (see Table). The co-directors of "The Natural Connection" believed that promoting cultural awareness would increase students' self-esteem, improve academic performance, and decrease self-destructive behaviors. They also felt that participation in traditional ceremonies and practices would offer students desirable, drug-free alternatives.

dents through courses on traditional Native American values, customs, ceremonies, and history. IAIA is a private, nonprofit educational institution whose students came from over 70 Tribes in 27 states. Many of the students grew up in

## APPROACH

The components of The Natural Connection were classroom discussions, assigned readings, and participation in ceremonies conducted by invited elders from around the country. A sweat lodge and medicine wheel were constructed on the IAIA campus. The invited elders were knowledgeable about their Tribe's beliefs, and values, and medicine ways. In addition to conducting ceremonies (such as the pipe ceremony, sweat lodge, and Navajo Blessing Way), the elders served as role models, discussing their personal challenges and how cultural identity and spirituality contribute to the resiliency of Native American people. They emphasized the importance of connections: to the earth, to Spirit, and to all living creatures.

The students provided a great deal of input into the course content and structure. They suggested books and articles to read, respected medicine people to invite, and ways to expand the course experiences. Books that were required reading included:

- Beck, PV; Walters, AL; Francisco, N: *The Sacred: Ways of Knowledge, Sources of Life*. Tsaille, AZ, Navajo Community College Press, 1992.
- Black Elk and Neihardt JG: *Black Elk Speaks*. Lincoln, NE: University of Nebraska Press, 1988.
- Thomas Mails: *Secret Native American Pathways: A Guide to Inner Peace*. Tulsa, OK: Council Oak Books, 1988.
- Steltenkamp MF: *Sacred Vision: Native American Religion and Its Practice Today*. New York, NY: Paulist Press, 1982.

## RESULTS

This project was successful in developing an innovative curriculum for students from many different Tribes and many varied experiences with traditional ways. Through readings, class discussion, and ceremonies led by recognized elders, the Natural Connection was able to incorporate traditional values and ceremonies into an academic structure. Because of their grounding in education, psychology, and spirituality, the course leaders could help students address substance abuse and social-behavioral issues in a safe, humanistic, and spiritual context.

The most telling statements about the program's success come from essays by the students themselves:

*"After being born into an alcoholic, dysfunctional, Indian family, and placed in a White Baptist Children's home, my culture and identity evaded me. The class helped me fuse back with my original Indian bond...I'm positive that my energy, education and life-work will be focused on the healing of the Indian community. Nothing else matters."*

*"I didn't feel anything for anyone except hate for myself. I hid my pain well from my family...I believe this class was my first step to being whole."*

*"Ceremonies make the person aware of their contribution to the life of the People and the meaning of life in general. When the individual is accepted, loved, and honored in this way, they know that life is worth living. It gives them self-esteem."*

*"The sweat lodge can be an especially helpful ceremony for re-centering, healing and purifying. During both of my two sweats I had breakthrough experiences in healing my soul and mind...When there is healing internally, drugs and alcohol may no longer be necessary."*

*"I think it is really an honor and a treasure to be part Native American...I know these belief systems have long been inside of me; they are from my ancestors. I want my knowledge to grow and grow. I want to learn how to stomp dance and how to speak our language. Someday I may even be able to practice some sort of medicine."*

*"In the sweat lodge I was at one with all natives. I felt so honored to be there...I felt powerful. I knew there was nothing I couldn't do. I found myself weeping uncontrollably, letting go all the pain I had ever felt and all the pain real or imagined my family had ever felt...It's like being reborn."*

*"Instead of just telling my children about our traditions, I have been able to participate with them in ceremonies and prayers. This has strengthened our relationship and my confidence as a mother and a guardian of our future generations."*

Unfortunately, financial and administrative crises at IAIA resulted in the discontinuation of the Natural Connection. The essence of the program, however, has been recorded in both a published article and videotape.

Three aspects of the program need to be considered before assuming it would be successful in other settings. First, the instructors were both psychologists as well as educators with extensive background and interest in traditional/spiritual issues. Because the Natural Connection combined didactic sessions, experiential learning (ceremonies) and group sharing (where skills in group process would be critical), very special individuals would be needed as course leaders. Second, the courses were voluntary, not mandatory. Whether participation and subsequent positive impact would be anywhere near as extensive if students were required to attend the class is a matter of conjecture. Third, the elders invited to present at IAIA were personally recruited by the instructors. Without enormous personal sensitivity and knowledge of traditional networks, access to "bonafide" elders would be difficult, if not impossible.

## RESOURCES

Jay Navarro, PhD, 1878 Camino Lumbre, Santa Fe, NM 87505-5612. Dr. Navarro was the director of the "Natural Connections" program.

Snedon, M; Kruzic, D: Videotape: "The Natural Connection." Colores Number 131, KNME-TV, Albuquerque, NM, May 16, 1990. Available from the KNME-TV Store at 1-800-328-5663. Includes interviews with students of the IAIA program.

Jay Navarro, Stan Wilson, Lawrence Berger, Timothy Taylor: *Substance abuse and spirituality: A program for Native American students*. American Journal of Health Behavior 1997;21(1):3-11.

Daniel Inouye: *Our future is in jeopardy: The mental health of Native American adolescents*. Journal of Health Care for the Poor and Underserved 1993; 4(1):6-8.

Teresa LaFromboise: *American Indian Life Skills Development Curriculum*. University of Wisconsin Press, Madison, Wisconsin, 1996.

# TRIBAL ELDERS HEALTH PROTECTION PROGRAM

Jamestown S'Klallam Tribe, Sequim, Washington

For elders, the combined factors of growing old, being Indian, and living in a rural area present great difficulties in obtaining adequate health care. Elders of the Jamestown S'Klallam Tribe in Northwest Washington State faced additional challenges. The Tribe was small (serving 400 Indians in a two-county area, 226 of whom were enrolled members) and only recently federally-recognized. There were few Tribal services and little

*Based on the ... enthusiastic response of community members, the Tribe greatly expanded its social and health services.*



community cohesion. Tribal customs, traditions, and language were at risk of disappearing. In 1990, the Tribe had an administrative staff of seven. Its health care program consisted of a Community Health Nurse (CHN) funded for one day per week. This minimal program could not begin to meet the needs of elders with medical problems, let alone provide care to prevent illness and protect their health. Because of difficulties in navigating the medical system, lack of transportation, and distrust, many elders were reluctant to seek medical care until they were critically ill.

## APPROACH

With funding from the Robert Wood Johnson Foundation, the Tribe hired a community health representative (CHR) for three days a week and increased the services of the CHN from one to three days per week. They made home visits to identify elders, deliver meals, provide direct care (e.g., blood pressure monitoring, diabetes control), facilitate referrals, and encourage participation in community activities. They also helped elders deal with paperwork and billings from Medicare, IHS, and private insurers.

The community needs assessment survey had questions about housing, family membership, employment, and cultural practices. Because Tribal members had become widely dispersed, the survey was also used to locate where other Tribal members were living. Household members were also

asked about where they received medical care and what problems they had accessing services. The willingness of people to participate in the survey was largely due to the rapport the health workers had established through their home visits.

In addition to their medical needs, the survey revealed that many elders were socially isolated and had few financial resources. Special activities for elders were therefore organized, including field trips, health fairs, monthly luncheons, and classes in traditional crafts. Extensive efforts were also made to involve the elders in recovering and reinvigorating Tribal traditions and practices. (See table on next page.) A summer cultural program for children was begun with storytelling, crafts, games, dancing, songs, and language instruction. Mrs. Ellen White, a medicine woman, educator and midwife from Nanaimo, British Columbia, was invited to meet with the elders. She conducted ceremonies and gave presentations on spiritual healing, "the old ways of solving problems," and the traditional use of herbs. The Tribe sponsored Annual Wellness Dinners at which there were traditional foods (salmon, elk, venison), drumming, singing, dancing, and giveaways.

## RESULTS

Based on the findings of the needs assessment survey and the enthusiastic response of community members, the Tribe greatly expanded its social and health services. The Tribe created full-time positions for the CHR, CHN, health and social services directors, and Elders Coordinator. Tribal services now include community health, health education and disease prevention, highway safety, nutrition (WIC clinic, food vouchers, commodities program, home-delivered meals), elder services, family preservation and support, youth and children's program, mental health, dental, assistance programs (general assistance, home energy, higher education, employment counseling, housing, and child care), and an active cultural program. A full-time chemical dependency counselor, who is also a spiritual leader, conducts sweat lodges and utilizes a "Medicine Wheel" model to guide individuals in recovery.

The Tribe now has 54 staff serving 600 Indians, 375 of whom are enrolled members. Because of its small size, lack of a Tribal health





clinic, and limited availability of services from IHS, the Tribe sought other methods to provide primary care services for its members, many of whom are low-income. The Jamestown S'Klallam Tribe's innovative Managed Care Program (MCP) used Tribal general revenues and IHS contract care funds to purchase private and governmental insurance for the uninsured. The MCP also pays for most of the deductibles and coinsurance requirements, as well as for Medicare Part B premiums. A key component for the program's success is the State of Washington's Basic Health Plan, which offers insurance to eligible, low-income participants.

Realizing the importance of strong economic and political bases in creating new opportunities for its members, the Tribe has established several businesses, including an oyster processing plant, excavating company, three art galleries, two apartment buildings, a business park, fireworks stand, and gaming casino. Tribal leaders are active in health affairs at the state and national levels. They serve on the American Indian Health Commission for Washington State, Northwest Portland Area Indian Health Board, and National Congress of American Indians.

The health program invested a great deal of effort to collect quantifiable information from surveys and conscientious medical record-keeping. This allowed the program to receive Tribal Council support in the face of numerous competing issues

(such as economic development, fishing rights, environmental protection, and housing shortages). It also enabled the Tribe to tap into a variety of funding sources, such as Tribal compacting funds from the IHS for health services, a grant from the Administration for Native Americans for drug abuse treatment, and Title VI funds for nutrition and other Elder services.

## RESOURCES

Liz Mueller, MSW, Director of Social Services, Jamestown S'Klallam Tribe, 1033 Old Blyn Highway, Sequim, WA 98382.

*Baseline Measures Work Group Final Report.* IHS, Rockville, 1996. A public health-oriented approach to health system assessment consistent with Tribal self-determination.

Andy Schneider and JoAnn Martinez: *Native Americans and Medicaid: Coverage and Financing Issues.* Report from the Center on Budget and Policy Priorities for The Kaiser Family Foundation Commission on the Future of Medicaid, December, 1997.

## REGAINING TRADITIONS

Conduct language classes.

Recover artifacts from museums, universities, and other sites.

Tape record oral histories to preserve stories, songs, games, customs, and knowledge about traditional plants for food and healing.

Research books, articles and photographic archives to obtain information about Tribal history, leaders, customs, clothing, games, and other practices.

Videotape elders demonstrating traditional songs, dances, crafts, and skills, such as basket-making, boat-making, and carving.

Invite spiritual leaders from closely-affiliated Tribes to share their ceremonies and traditional wisdom.

Incorporate into health care traditional approaches to healing, such as herbs, ceremonies, and sweat lodges.

Create cultural programs for children and youth including presentations by elders and experiences in traditional ways: hunting, fishing, healing, sweat lodges, vision quests.

Establish pow-wows and other public gatherings to promote traditional foods, dances, drumming, singing, pot-latches, and giveaways.

# INTER-GENERATIONAL HEALTH AND NUTRITION PROGRAM

## Pueblo of Isleta, New Mexico

Inter-generational activities are highly valued in the Pueblos. They are critical to the continuance of language, traditions, ceremonies, healing, agriculture, worldview, and philosophy. Yet in the Pueblo of Isleta in 1990, a community survey found that many Pueblo residents did not have a nearby family network for social interaction and sharing traditional ways. 53 percent of the Pueblo elders lived alone. Others lived with adult children and were alone during the day. At the same time, there were 1,200 school-age children in the Pueblo, but there was no community gym, park, or swimming pool for exercise and recreation.

### APPROACH

The Isleta Elderly Advisory Committee, Head Start personnel, and project staff designed this inter-generational project. Head Start children were transported to the Isleta Elderly Center. Activities were chosen that both elders and children could enjoy and which could provide health and social benefits. Nutrition, exercise, culture, and language were emphasized. "Many of us have diabetes," one Elder said. "We have feasts for everything—Baptisms, marriages. They last all day, and a lot of what we eat are cakes, pies, and puddings."

*On Thanksgiving, the children visited the elders in their homes and helped prepare foods for a shared meal.*



flour, low fat powdered milk, and vegetable shortening instead of lard. There was a weekly physical exercise class where Native words were used for counting repetitions. The children spent time with elders gathering traditional vegetables (corn, wild spinach, and asparagus) and preparing tradi-

Elder volunteers recruited and trained. The training included discussions of the Tiwa language, Native foods (nutritional value, cultural history, traditional dishes and methods of preparation), and how to involve children. One Elder who owned a bakery prepared traditional bread using 50 percent whole wheat

tional foods (such as Indian bread and atole, a blue-corn drink or cereal). The children and elders ate lunch together, alternating trays at the lunch line. Everyone wore name tags with their nickname, Indian name (which allowed identification of family and clan), and "who my parents are." On Thanksgiving, the children visited the elders in their homes and helped prepare foods for a shared meal.

### RESULTS

This project was of direct benefit to participants of all ages. It enhanced their self-esteem, social interaction, physical fitness, and knowledge of nutrition, Tiwa language, and traditional culture. The benefits extended to families throughout the community, since many of the elders provide childcare to their grandchildren.

Foundation support was crucial to this project because agency funding for inter-generational work is rare. As one advocate stated: "Dollars are earmarked for seniors only or for children only. Yet inter-generational work requires a salaried intermediary committed to both elders and kids."

The inter-generational program laid the foundation for collaborations with the University of New Mexico (UNM). A faculty member from UNM's College of Education, Dr. Paul Miko, established a weekly program of therapeutic exercise for the frail elderly and kindergarten children. Students in therapeutic recreation assisted him. Isleta also became a demonstration site for a model diabetes control project led by Dr. Jeanette Carter. The project provided a lifestyle curriculum with five goals: increase exercise, decrease fat, decrease sugar, offer support for changes, and facilitate maintenance of healthy choices.

The Elder program has grown to a \$200,000 annual budget with nutrition activities, arts and crafts, inter-generational activities, and advocacy projects. The Pueblo of Isleta became the first Indian community in the state to have an AARP chapter. Inter-generational work continues through the Foster Grandparent Program. The children's age group has been expanded to elementary and high school students. There is storytelling by elders, shared lunches, and a weekly inter-generational exercise class at the Elderly

Center. School children visit the Elderly Center on holidays, exchanging gifts and cards for Valentine's Day, Christmas, and Halloween. Future plans include a joint gardening project for traditional/healing/ceremonial plants, visits by children to elders' homes to help with chores, and children teaching elders about computers. Computers can benefit elders as entertainment and by providing information on health, federal assistance, and other issues.

Generations United, a national coalition dedicated to intergenerational policy, programs, and issues, summarizes the benefits of intergenerational programming:

- facilitates community collaboration, pooling resources, and cooperative problem-solving;
- promotes an appreciation for rich cultural heritages, traditions, and histories;
- applies the strengths of one generation to meet the needs of another;
- prevents unnatural age segregation, increasing community awareness about issues that affect both young and old;
- enhances the ability of public and private agencies to meet family and community needs.

These benefits are especially important to Native American communities. Intergenerational activities help restore the traditional place of elders as profoundly respected keepers of Native traditions, history, language, and wisdom.



## RESOURCES

Betty Johnson, Elders Program, Pueblo of Isleta, PO Box 317, Isleta, NM 87022.

Davis, SM; Hunt, K; Tso, H: *Oral histories and traditions: An inter-generational approach to health promotion*. Journal of Navajo Education, Spring 1990; 7(3):23-27.

National Resource Center on Native American Aging, PO Box 7090, Grand Forks, ND 58202-7090 (Phone: 1-800-896-7628). Website: [www.und.nodak.edu/dept/nrcnaa/](http://www.und.nodak.edu/dept/nrcnaa/). "Through education, training, technical assistance, and research, the center assists in developing community-based solutions to improve the quality of life and delivery of related services" to the elderly Native American population.

Generations United, 440 First Street N.W., Suite 310, Washington, D.C. 20001-2085. Website: <http://www.gu.org/>

National Indian Council on Aging, 10501 Montgomery Blvd. NE, Suite 210, Albuquerque, NM 87111.

# SWEAT LODGES AND SUBSTANCE ABUSE

Lawton, Oklahoma

Kenneth Coosewoon (Kiowa/Comanche) is both a sweat lodge leader and a certified alcohol and drug abuse counselor. More than a decade ago, he became convinced of the value of the sweat lodge for the prevention, treatment and aftercare of individuals 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. The process is extremely non-threatening, thereby allowing the participants to display more openness and a willingness to experience the physical and purifying effect. The experience can enhance exist-*

*The sweat lodge experience may involve prayers, singing, a ceremonial pipe, and sharing personal thoughts and feelings.*

*ing alcohol and drug prevention program activities and services. The sweat lodge is not a therapy, but can be considered a significant collateral component to therapy."*

*"The sweat lodge offers a spiritual process for participants to nurture and renew spiritual awareness, self-worth, and balance for their personal and*

*professional lives...Many have found the freedom to release confusion, guilt, frustration, and anger through their expanded spiritual awareness. The power of prayer is the basis of the sweat. Unlike AA, which emphasizes that once a person is an alcoholic, they are always an alcoholic, a person on a spiritual path can see himself as a warrior who can conquer his alcoholism. The sweat lodge promotes healing mentally, physically, emotionally, and spiritually."*

## APPROACH

Structurally, the sweat lodge is usually a dome-like frame covered by canvas or other materials with a single entrance. Volcanic rocks are heated in a wood fire near the lodge. A fire-keeper brings the rocks to a pit on the floor of the lodge and closes the entry flap. The sweat lodge experience

may involve prayers, singing, a ceremonial pipe, and sharing personal thoughts and feelings. When Kenneth conducts the lodge for participants with substance abuse problems, he often provides counseling and referrals:

*"Many times there isn't room at treatment centers and short-term counseling must be done to keep the client interested in treatment until space is available."*

*"I conduct the sweat in English. We don't charge any fee. At most, there are 25 people. I review 'do's' and 'don'ts', such as if it gets too hot, to leave and return in the next round. Both men and women, Native and non-Native, can enter the lodge. No one who is drinking or using drugs is allowed to participate. If the lodge is used for sobering up, it can lead to harm."*

*"The lodge is universal. The messages are about how important it is to be kind to all the Great Spirit's creations, about how you're as important as anyone else even if you are living on the street, about how helping other people can help your own recovery. A lot of the experience is about learning how to pray. It's important to pray for those sicker than you, to forgive people and pray for them. It helps to provide a release. For some, the experience is like being reborn."*

*"The lodge is not a cure-all, it's a start. 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, AA, or other places."*

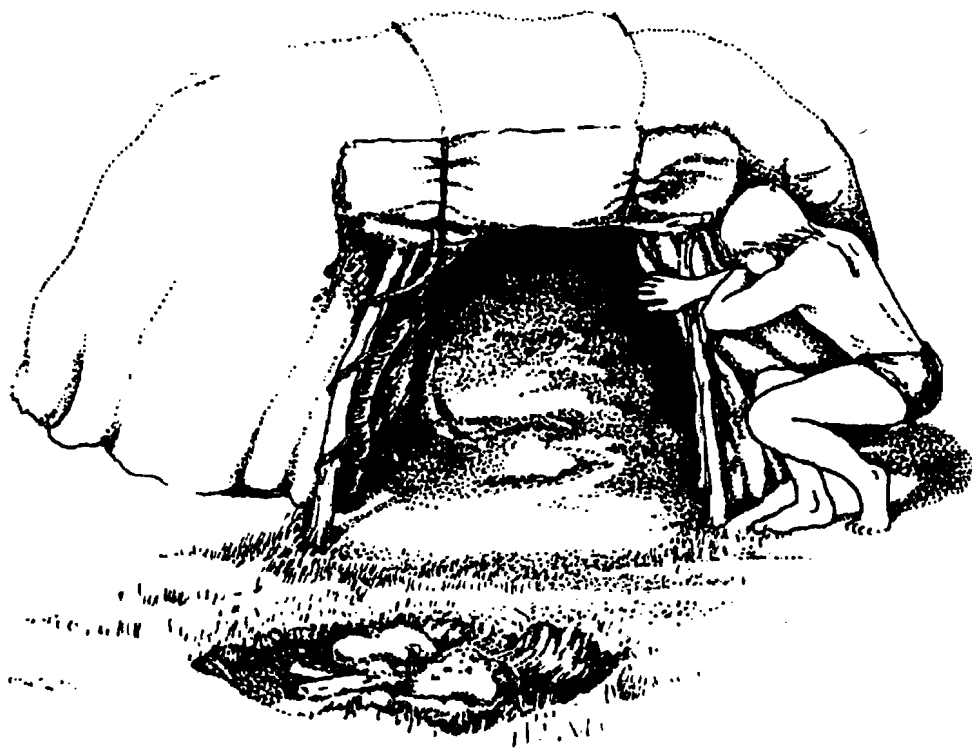
## RESULTS

During the one-year grant period, an estimated 1,400 people attended the sweat lodges. Seven sweat lodges were built for aftercare/follow-up service, 13 were used as alternatives to alcohol/drug use, and 5 were established in prisons. (While eight percent of Oklahoma's population is Native American, 22 percent of the prison population is Native.) Fifteen participants are now conducting sweats for their own communities. They see this as a service to others, and as a path for their own continued sobriety. "I tell them how important it is for a leader to listen, be honest, have humility, a good heart, and earnestness to help people. The

leader must respect the lodge, not misuse it. Leaders shouldn't smoke or drink, and always try to be a better person to run the sweat.

A psychologist at the local IHS facility is enthusiastic about the sweat lodges: "This service has proven to be a powerful personal experience for numerous individuals, both Indian and non-Indian, male and female, young and old. The program accepts everyone, the homeless and chronic alcoholics, people no one else is addressing. It has served as a gateway to AA, the Native American Church, and other helping organizations."

Sweat lodges are not without hazards. Dehydration and fainting can affect anyone not accustomed to the prolonged heat and humidity. Individuals with serious medical conditions (such as diabetes or high blood pressure), pregnant women, young children, and the elderly should seek medical advice before participating. For most healthy individuals, regular sweat lodges can be a source of spiritual renewal, physical rejuvenation, and enhanced personal well-being.



## RESOURCES

Kenneth Coosewoon, PO Box 408, Lawton, OK 73502

Lawrence Berger and Eric Rounds: *Sweat lodges: A medical view*. IHS Primary Care Provider, June, 1998.

Joseph Bruchac: *The Native American Sweat Lodge: History and Legends*. Freedom, CA, The Crossing Press, 1993.

# CULTURALLY-BASED PROGRAM TO IMPROVE MATERNAL & CHILD HEALTH

Great Lakes Inter-Tribal Council, Inc.,  
Lac du Flambeau, Wisconsin

The "Grandmothers and Aunties" (GA) project sought to improve maternal and child health status by strengthening social supports among Tribal women, revitalizing traditional nurturing systems, and improving coordination of services. The project was created in response to an infant mortality rate among Native Americans in Wisconsin that was twice the rate for the state overall. There were also concerns about the high proportion of pregnant women not receiving early and adequate prenatal care, a high teenage pregnancy rate, and the absence of support networks for many childbearing women.

## APPROACH

Meetings were held with community members at each of the eleven Tribes that are members of the Great Lakes Inter-tribal Council (GLITC). Participants were asked to describe barriers to services, identify resources, and propose ways to involve elders and develop outreach and social support activities for the families of childbearing age. (See table on next page.) This community planning phase helped build the trust necessary for new partnerships and created the foundation for community ownership and empowerment.

In each community, project staff then facilitated the creation of a "Family Support Team" (FST). Members of the FST might include health and human service staff working with maternal/child health (MCH) programs, community health outreach, WIC, substance abuse, domestic violence, and parenting programs. The teams focused on developing parenting skills; decreasing the use of alcohol, tobacco, and other drugs; increasing the number of women who received prenatal care in the first trimester of pregnancy; and coordinating services to families. Team-building retreats were held to address turf issues (paraprofessional/professional, Tribal/non-Tribal persons and agencies, mental health/substance abuse, medical/social services), improve skills in communication and conflict resolution, and build on the strengths and resources of each team member.

Each Tribe also established a Council of Elders. By taping and transcribing discussions among the



elders, project staff recorded traditional cultural and psychosocial health practices related to pregnancy, childbirth, women's health, and child care. The Elders Councils decided how the manuals were to be used (e.g., training of providers or informing parents). The council members also provided leadership for the project, conveying to the education, health, and social service staff that it was "important to buy into this." Elders also participated in women's support groups, taught language classes, and demonstrated traditional crafts. An Inter-Tribal Elders Coordinator provided direction and technical support to the Elders Councils.

To recreate the traditional support system for families, "foster" grandmas and aunties were hired and trained. They worked part-time (20 hours a week), providing outreach and social support to women of childbearing age. These outreach workers used their own initiative to determine what would be most helpful for the families. Their activities included transportation to appointments, patient advocacy, health education, and child care. The Grandmas and Aunties also brought cases to the FST for problem-solving, made referrals to health, social, and substance abuse services, and identified key extended family members to be involved as additional sources of social support.

The increased involvement of men during pregnancy, childbirth, and parenting was another program goal. During their home visits, the foster Grandmas encouraged increased participation by fathers. Inter-tribal gatherings of men were organized, including sweat lodges, discussion groups, and educational presentations. The Grandmas vis-

ited pipe carriers, asking them to encourage men to attend the gatherings. Women's inter-tribal gatherings had previously been successful in promoting the program, helping women problem-solve, offering support, and building community networks.

## RESULTS

Each Tribe was unique in its needs, cultural practices, and spiritual emphases. Therefore, although all the programs used the same basic approach, each Tribe developed its own procedures, care plans, assessment forms, and women/child health promotion plans.

In one community where transportation needs were particularly great, the Community Health Representatives assumed responsibility. In another Tribe, a foster grandmother not only made home visits, but also accompanied women during childbirth. A satellite clinic for well-child care, immunizations, and WIC was created in a third community.

The Grandmas and Aunties project prompted the GLITC to review all their programs for cultural appropriateness. The WIC program, for example, no longer teaches nutrition using the "food pyramid" but a circular model with traditional foods. The team-building activities developed for the project have been extended to networks at the agency, regional, and state level. The GLITC was successful in obtaining funds for their women's and child health activities from the Center for Substance Abuse Prevention (CSAP); the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); and Wisconsin's Rural Infant Health Program. Most recently, they received a four-year, Healthy Start grant for outreach, education, and collaboration in maternal and child health. The Grandmas and Aunties project received the DHHS Secretary's Award for Excellence and Wisconsin's Maternal Child Health Award for being the state's outstanding outreach program.

## RESOURCES

Dale Wolf, Great Lakes Inter-Tribal Council, Inc., 2932 Highway 47 North, Lac du Flambeau, WI 54538

*The Children Come First: An Elder's Manual about Healthy Pregnancy and Parenting Practices.* Great Lakes Inter-Tribal Council, Lac du Flambeau, Wisconsin, 1994.

AAP Council on Child and Adolescent Health: *The role of home visitation programs in improving health outcomes for children and families.* Pediatrics 1998;101:486-89.

*Restoring Balance: Community-Directed Health Promotion for American Indians and Alaska Natives.* Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, Stanford University, Stanford CA 94305, 1992.

### ELEMENTS OF A WOMEN'S HEALTH/ CHILD HEALTH PROGRAM

#### OUTREACH:

- identify pregnant women, sexually active women, domestic violence, other family needs
- follow-up for families for health promotion, medical and psychosocial issues
- case management/coordination of care among agencies, providers
- assist with transportation
- tracking of referrals, follow-up appointments, adherence to regimens: on- and off-reservation

#### MEDICAL, SOCIAL, AND OTHER SERVICES:

- Education and job opportunities, budgeting, eligibility for assistance (financial, housing, Medicaid, food stamps, etc.)
- Family planning education and services
- Sexually transmitted diseases, AIDS education and services
- Pregnancy tests for early identification of pregnancy
- Prenatal care
- Prenatal classes for women and their partners
  
- Deliveries: childbirth support, in-hospital visits
- Post-partum: breast feeding support, father's involvement, depression, complications
  
- Primary health care, including pediatric and gynecologic care (pap smears, mammography)
- Substance abuse treatment and after-care
- Domestic violence prevention and services
- Nutrition/WIC, dental, and mental health services
- Early intervention services for children with special needs
  
- Parenting education and support: child development, health, and safety
- Fathers involvement: prenatal classes, parenting, anger management
- Day care/child care services
- Inter-generational activities
  
- Community activities: women's and men's gatherings; presentations to schools, community groups, and providers.
  
- Interagency collaboration: formal and informal networks at the local and state levels.

# ADOLESCENT PREGNANCY AND PARENTING PROGRAM

## Navajo Nation, Ganado, Arizona

At Ganado High School (GHS), where 99 percent of the 800 students are Navajo, one out of five girls were already mothers or were pregnant in 1989. In the fall of that year, many people in the community began to "openly and strongly express concern over the teenage pregnancy problem and associated health issues." More than half (55 percent) of the students who became pregnant did not receive early prenatal care, in part because of geographic isolation, poor roads, and medical services that did not emphasize the special needs of teenagers. With no day care services in the community, many teens simply dropped out of high school to care for their infants and attend medical appointments for themselves and their children.

### APPROACH

The Ganado Unified School District (GUSD) took a multi-faceted approach to its Comprehensive Adolescent Pregnancy and Parenting (CAPP) Program. The program was supported by unanimous resolutions of the Navajo School Board and Ganado Chapter (the local

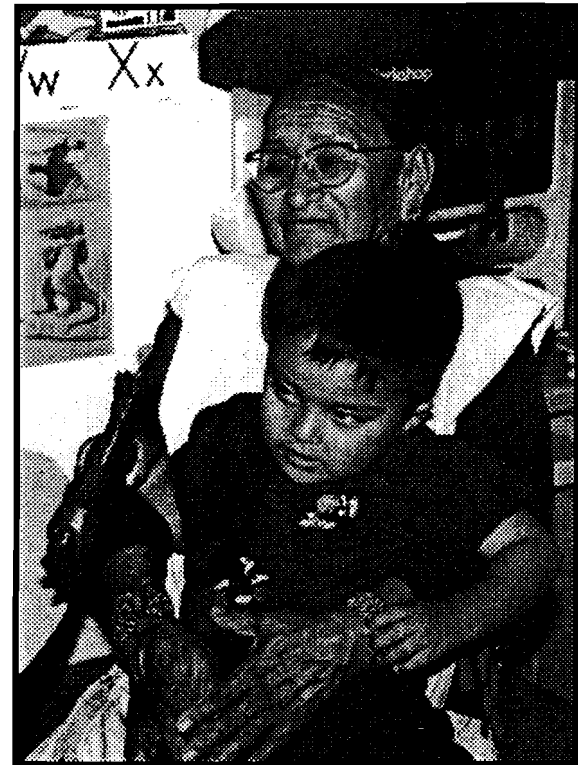
Navajo governing body). "We maintain a Native American Philosophy which looks to the four sacred Navajo Mountains for its direction. The North or Dibe' Nitsa' represents healthful living strategies."

The program was a collaboration among community members, GUSD, Indian Health Service, the Navajo Nation Health Foundation (which operates Sage Memorial Hospital in Ganado), Navajo Nation agencies (such as the Navajo Foster Grandparent Program), BIA, and the

Arizona Department of Education.

#### *For pregnant teens:*

Prenatal clinics were begun on the high school campus. Sage Hospital donated equipment and supplies and scheduled a provider to visit the



school once per week. A childbirth education class, taught at the high school and attended by pregnant students and their partners, used a curriculum developed by Navajo elders, a Navajo counselor, a curriculum specialist, and the home economics teacher.

#### *For parenting teens:*

Post-partum clinics were offered at the high school. Training in parenting skills, including traditional Navajo values and customs, was provided through the Navajo Foster Grandparent Program. Foster Grandparents are volunteers who provide cultural awareness, teach traditional knowledge and skills, offer expertise in raising children, and assist in the care of the children at the day care center. A child care and guidance class was taught by the home economics teacher. Talking Circle support groups were offered as an after-school program for pregnant students and partners. CAPP staff made home visits to prenatal and parenting students. Expanded educational options were made available: after-school tutoring for English and math, homebound and summer school programs, and individualized teaching plans.

#### *For the children of teens:*

Well child clinics were offered at the high school staffed by a physician and nurse practitioner from Sage Hospital. A Child Care Center was opened on the high school campus, in a facility

*Training in parenting skills, including traditional Navajo values and customs, was provided through the Navajo Foster Grandparent Program.*





adjacent to the classroom building. "The majority of students who use the center cite it as the major reason they have been able to stay in school." Children ages four months to five years are enrolled. At least one parent must enroll in the child care and guidance class at GHS. The Center has three paid staff and two volunteers from the Navajo Foster Grandparent Program. The policies and practices at the Child Care Center provided a model for good nutrition, alternatives to spanking, expression of feelings, and age-appropriate activities. Cultural activities—Navajo language and traditions, nature exploration, cooking, art, songs—occur throughout the day. Parents and other students work in the center to gain experience and class credit. A staff development program allows child center workers to study for the Child Development Associate Degree.

**For teens at risk:**

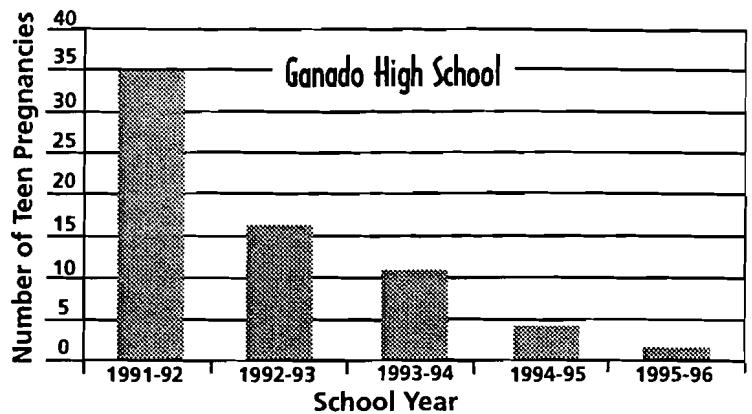
A value-based curriculum on pregnancy prevention/sex education was incorporated into health and physical education classes at the high school. Teen mothers formed a group called Peer Action Leader Students (PALS). The group made classroom presentations to promote pregnancy prevention. In addition to prenatal care, the clinic at GHS offered pregnancy prevention information and pregnancy tests. Condoms were available through a shopping center and the pharmacy at Sage Hospital. The high school Vocational Department began an "Occupational Child Care" class where students spent time in the child care center as an essential part of their learning experience.

**Community involvement:**

A Community Advisory Committee was established to help develop the pregnancy prevention/sex education curriculum and to offer guidance in all aspects of the CAPP. Public hearings were held before the curriculum was implemented.

**RESULTS**

The number of teen pregnancies at Ganado High School fell steadily from 35 in the 1991/92 school year to 2 in 1995/96. (See graph this page.) Whereas 9 students failed to complete high school because of pregnancy in the 1991/92 academic year, none had to drop out since the program began. More than half of the pregnant teens who completed high school went on to college. The percent of pregnant teens receiving prenatal care in the first trimester rose from 45 percent to 100 percent.



All the program components interact to promote healthy families. The Child Care Center obviously teaches parenting skills and allows teens to complete their high school education. It also helps to prevent pregnancies: students spend time in the center learning how demanding child care can be, and watch their parenting classmates come to school balancing babies, blankets, bottles, and book-bags! As one student remarked, "You have to care for them every second — that really got me thinking."

The pregnancy prevention/sex education curriculum was implemented district-wide after CAPP highlighted its value. The Child Care Center expanded its services to include children of employees and community members. Additional support for the program was obtained from the Flinn Foundation, Arizona March of Dimes, and Save the Children Foundation. Other funding comes from state child care and nutrition programs, and from child care fees. The hospital and school continue to lend support. A site visitor observed: "It is very obvious that the project staff's enthusiasm, commitment, and dedication to the students at Ganado are the key components of the project."

**RESOURCES**

Laverne Jimmy, Comprehensive Adolescent Pregnancy and Parenting (CAPP) Program, Ganado High School, Highway 264, Ganado, AZ 86505.

Moore, Kristin A.; Sugland, Barbara W; Blumenthal, C; Gleib, D; Snyder, N: *Adolescent Pregnancy Prevention Programs: Interventions and Evaluations*. Child Trends Inc., 4301 Connecticut Avenue NW, Suite 100, Washington, DC 20008. June, 1995.

The National Campaign to Prevent Teen Pregnancy, 2100 M Street, NW, Suite 300, Washington, DC 20037.

# SUGGESTIONS FOR IMPLEMENTING NEW TRIBAL HEALTH PROGRAMS

Regardless of the topic area (substance abuse, diabetes, domestic violence, etc.), two immediate questions arise each time a new health program is considered. First, what kinds of programs have been proven effective in other communities? Second, where can funding be obtained for the new program? These questions are briefly addressed below, along with suggestions for sharing your experiences with other Tribes and communities.

## IDEAS FOR EFFECTIVE PROGRAMS

Researching programs that have been successful in other communities can save a great deal of time, effort, and money. It also is essential in convincing funding sources that your proposed new program deserves support. Consider the example of a Tribal health department designing an initiative in diabetes prevention and control. Two approaches the planners might consider are a school-based curriculum to promote good nutrition and reduce obesity and an educational program for people with diabetes to prevent complications. Model programs for both these options

*[Programs that have been successful are...] essential in convincing funding sources that your proposed new program deserves support.*



a lifestyle education program for people with diabetes and their families called, "Strong in Body and Spirit!" The curriculum is on the Internet ([www.laplaza.org/dwc/prof/NADP/index.htm](http://www.laplaza.org/dwc/prof/NADP/index.htm)) and team-training is offered for Tribes wishing to implement the program. Both Pathways and

have been designed and field-tested. The Pathways Project uses classroom lessons, school meals, physical education and family programs in a collaboration among seven Indian nations, five universities, and the National Heart, Lung, and Blood Institute. (The Pathways Coordinating Center is at the University of North Carolina in Chapel Hill). The Native American Diabetes Project

(NADP) has developed

NADP are nationally-recognized programs offering state-of-the-art diabetes interventions.

Identifying relevant programs requires some detective work. Some of the most useful approaches are: contacting directors of existing Tribal health programs, contacting the offices of national organizations and agencies, and "surfing the Internet." Attending workshops on Native American health issues is another opportunity to discover who is participating in innovative programs around the country. On the national level, the Indian Health Service provides consultation in such areas as diabetes, substance abuse, and injury prevention. National organizations exist for most conditions, from Alzheimer's disease to fetal alcohol syndrome to domestic violence prevention. The Internet can be searched by entering the health topic, then narrowing the search with key words such as "Native American," "Indian," "prevention," "education," and "programs." A Native Health Research Database (NHRD) is under development at the University of New Mexico's Health Science Library. Directed by Tom Kauley (Kiowa), the database will provide on-line access to published research and program evaluations involving Native American health.

## SOURCES OF FUNDING

Funds are needed to plan, implement, evaluate, and maintain all types of health programs. A variety of funding sources should be considered:

- **Individuals:** In the United States, individuals contribute an estimated 80 percent of all philanthropic contributions;
- **Foundations:** These are non-profit organizations created by individuals or corporations to disburse grants for efforts in their areas of interest;
- **Businesses and corporations:** Their contributions can include cash grants, as well as human and material resources ("in-kind" contributions);
- **Government:** Funding can be local, state, regional, or federal;
- **Religious institutions:** From the local parish to national bodies, religious groups may offer financial support, meeting and office space, volunteers, and advocacy;
- **Community fund-raising organizations:**

These are non-profit organizations, such as United Way or the "community chest," consisting of groups of smaller organizations that pool their efforts in a fundraising coalition, usually with a common theme (women's issues, child health, the environment, etc.);

- **Community associations:** Many groups, such as service clubs (Lions, Elks, Shriners, Rotary), community action associations (e.g., Safe Kids coalitions), and professional groups (medical societies, teacher associations), may provide funding for community programs.

For each potential funding source, it is important to know:

- What types of programs do they fund?
- Who is eligible to receive funding?
- How much money does the agency or organization usually award?
- What is the specific procedure for requesting funds?

Be prepared to sell your program. Explain in detail what the funds or contributions will be used for. Business audiences may want more financial details. Community or school groups may appreciate human interest stories. Consider asking for in-kind contributions as well as money. Invite people to see your project in action or to meet with people served by the program.

How do you find out about what funding sources are available? The best ways are through books, newsletters, the Internet, and especially personal contacts. The last method often provides the best leads. For example, by calling the director of a Tribal health program, you can ask not only about project activities, but also about where funding was obtained and what opportunities are currently available for program support.

## LET OTHERS KNOW

When you've implemented a new health program, it's important to "complete the circle" by letting others know of your experience. What did you learn about funding sources, community involvement, and evaluation? What challenges did you have to overcome and what approaches did you find successful (or not)? Some of the ways to do this are to:

- create a videotape of your program, filming activities and interviewing key players and program participants;
- develop a slide presentation with accompanying written text keyed to the slides;
- write an article for publication in a newsletter or journal;
- give presentations at local, state, and national meetings and workshops;
- send out a news release to the local media, forwarding copies to agencies and organizations (such as the National Indian Health Board and IHS) likely to be interested in the results of your project.

In this time of reduced Federal support, changes in Medicaid and welfare programs, the ascendance of managed care, and increasing Tribal responsibility for health services, sharing ideas, experiences, and information is vital to assuring optimal health for Native Americans.

*Invite people to see  
your project in action  
or to meet with  
people served by the  
program.*



# SOURCES OF FUNDING FOR HEALTH PROGRAMS

## Major Categories and Examples

### THE INTERNET

1. The Foundation Center: <http://www.fdncenter.org>
2. Office of Minority Health Resource Center, funding database: <http://www.omhrc.gov>
3. The Robert Wood Johnson Foundation: <http://www.rwjf.org>
4. Society of Research Administrators Grantsweb: [web.fie.com/cws/sra/resource.htm](http://web.fie.com/cws/sra/resource.htm)

### NEWSLETTERS AND MAGAZINES

1. Chronicle of Philanthropy.
2. Foundation News and Commentary.
3. Children and Youth Funding Report.
4. Community Health Funding Report.
5. Substance Abuse Funding News.

### BOOKS AND PUBLICATIONS

1. **Cashing in on Funding Ideas.** Available from Join Together, 441 Stuart Street, 6th Floor, Boston, MA 02116. Free.
2. **Foundation Center Publications.** Titles include: *The Foundation Directory*, 1998 Edition; *Securing Your Organization's Future; Grant Guides in 32 Subject Areas; National Directory of Corporate Giving; Who Gets Grants.* Available from the Foundation Center, 79 Fifth Avenue, NY, NY 10003-3076. (Phone: 1-800-424-9836.)
3. **Multicultural Grant Guides: Native American Series.** Titles include: *Corporate and Foundation Fundraising Manual for Native Americans, Church Philanthropy for Native Americans and Other Minorities, The National Directory of Philanthropy for Native Americans.* Available from Corporate Resource Consultants, PO Box 22583, Kansas City, MO 64113-2583.
4. **Funding Resource Guide for Substance Abuse Programs.** Center for Substance Abuse Treatment, SAMHSA, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857. 1994. Free.
5. Satcher, D; Rosenberg, ML: **Guide to Applying for Injury Research Grants.** National Center for Injury Prevention and Control, CDC, 4770 Buford Highway, Mail Stop K-58, Atlanta, GA 30341. 1995. Free.

## About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation, based in Princeton, NJ, is the nation's largest philanthropy devoted exclusively to health and health care. It became a national institution in 1972 with receipt of a bequest from the industrialist whose name it bears, and has since made more than \$2 billion in grants. The Foundation concentrates its grantmaking in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve the way services are organized and provided to people with chronic health conditions; and to reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol, and illicit drugs.

## About the Author

Since arriving in New Mexico in 1979, Dr. Berger has been involved with Native American health through educational, consultation, and technical support activities with Tribes, the IHS, and other organizations. He is currently a research scientist at The Lovelace Clinic Foundation in Albuquerque. Dr. Berger has published many articles in the fields of Native American health, injury prevention, and maternal/child health. He has been a faculty member for the IHS Injury Prevention Fellowship program since 1992 and established a summer research fellowship in Native American health in 1994. He received the Native American Child Health Advocacy Award from the American Academy of Pediatrics in 1997.

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