Comprehensive Community Health Plan

How does the community perceive its health needs?

The reservation's first comprehensive community health plan was, in author Sal Sahme's mind, a "grass roots" effort. (see story in July 13, 1979 **Spilyay Tymoo,** page 8)

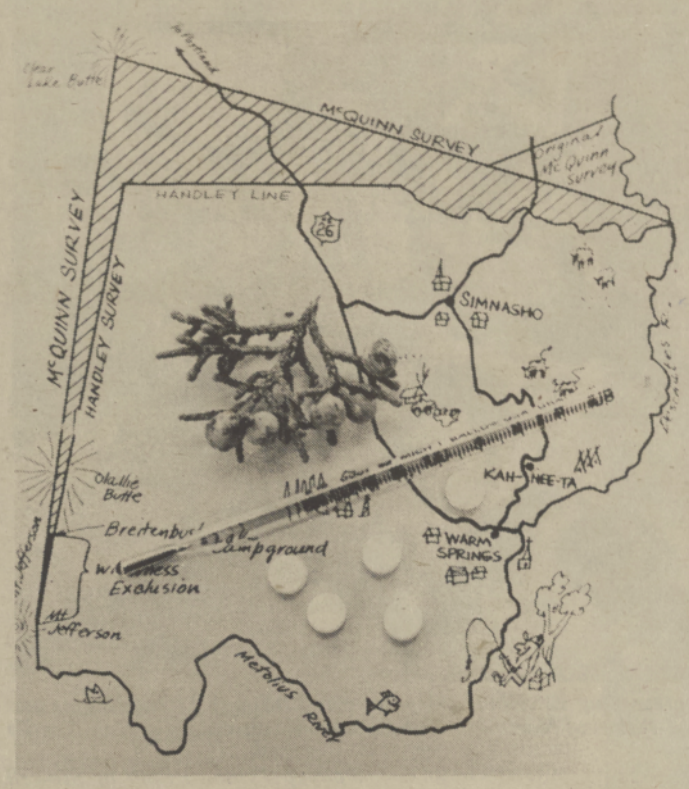
Community people were involved from the start and it is their tapped opinions that form the basis for the action steps outlined in the plan. At the core of the nine-month project was a needs assessment survey administered to a sampling of the population. This survey has supplied the Tribes with a wealth of informaton, much of which has yet to be thoroughly analyzed but which on the surface reveals a great deal about community attitudes.

The survey instrument itself is the product of community efforts. Five community groups — consumers, providers, elderly, students and management — were invited to come up with a set of questions they felt would get to the heart of the reservation's health needs and problems. From their list of 50 prioritized questions the survey instrument was developed, with the assistance of Indian staff from the White Cloud Center in Portland.

Nine interviewers—all staff members and tribal members—administered the survey to a group of 165 reservation residents selected randomly by computer. Only 108 completed the questionaire, a fact Sahme attributes to bad weather and a high number of deaths in the community.

After providing personal background information, the respondents were asked to rate existing programs, describe their health care experiences, list their health care needs, offer suggestions for solutions and comment on particular community health problems.

The needs of the elderly and children were emphasized in the questionnaire, because these groups are the most neglected, said Sahme. But facility and staffing needs were also tapped. The health care needs for the **elderly** most commonly acknowledged were



dental work (79.6% said yes) and **home health care** (76.9%). Social service needs of the elderly were perceived as first **transportation**(87%) and second **social interaction** (81.3%). Sahme said there was also an expressed interest in a foster grandparents program.

For children, **drug and alcohol education** (92.5%) and **recreation** (90.7%) topped the list with **traditional culture education** close behind (88.8%). Sahme noted that this indicated a desire for preventative rather than punitive measures, a trend he feels is already being pursued in the health branch.

Two-thirds of the respondents felt that the **Indian Health Service facility needed to expand**. About half of those said construction was needed to provide **more room**. People were more divided about the construction of a new Tribal health facility, with 51.2% seeing a need.

Health staffing was seen as inadequate; 77.6% felt that more staff was needed. Their reasons were varied, but revolved on increased **population demands** and **long waiting times.**

Respondents displayed a fairly good awareness of Tribal, I.H.S. and Bureau of Indian Affairs programs, although of the the three, the **Tribal programs were least known.** Of the Tribal programs, people seemed to be least aware of the crisis and outreach efforts (41.4% and 48%) and most aware of the alcohol treatment program 77.2%) and women, infants and children (WIC) (75.2%).

Evaluations of the programs did not seem to depend on awareness. In fact, a significant number of respondents, usually about one-quarter, did not wish to rate programs at all. When they did rate them, the overwhelming response was **"fair"** a fact that Sahme attributes to lack of exposure to services off the reservation. However, the WIC and Maternal Child Health programs were rated as "excellent". (34.2% and 29.4% respectively.)

There was a **high degree of awareness of I.H.S. services,** particularly outpatient (94%) and dental (88.9%), with field health services less known (65%). Again ratings were predominantly "fair." In the B.I.A., 78.6% knew about Individual Indian Monies (IIM) but only 46.8% were aware of resource-referral assistance.

By far the **most heavily used health care service** is the I.H.S. clinic (89%), with off-reservation services used by a very small percentage (5%) and preventative physical and recreational activities cited by only 3%. Availability was given as the reason for using the I.H.S. by 66.2% of the respondents. Two-thirds felt that their confidentiality was protected at the clinic.

But this heavy use has apparently resulted in **excessive wating times.** Over half the respondents said that on the average they wait over one hour to see a doctor. Waiting time is a little less for the dentist, with 41% waiting a half hour or more. Sahme said that on the basis of a two-day cursory visit to the clinic, an Office of Research Development team was prepared to recommend that more space be made available for outpatient and dental care. The final results of their time clock study will be completed in October and Sahme expects that the need for a new health complex will be indicated.

When respondents were asked if they felt existing programs were **meeting traditional needs** 51.9% said they were and 24.1% said they were not. Those who felt traditional needs were not being met pointed to a lack of cultural education among the staff. Sahme noted that generally the holistic approach being used increasingly by the health branch was working, but that some staff, even Indians, were out of touch with traditional values and could more effectively utilize elders as teachers. Staff needs to be more culturally sensitive not only in treatment methods but in ways of approaching and communicating with patients, said Sahme.

Use of **Indian medicine** was scarce, with 75.2% saying they did not use it. But 57.5% indicated they knew what Indian medicine was. Apparently the sources of Indian medicine are uncertain since the passing away of knowledgeable elders, said Sahme. He knows of only one traditional healer in this community and points to a reluctance on the part of knowledgeable people to share what they know. But with the proper encouragement and respect, elders might prove to be willing teachers.

Open-ended questions solicited the opinions of respondents on the causes of and solutions for alcohol and drug abuse. People made a sharp distinction between the two health problems. The **major causes of alcoholism** were perceived as family problems (27.4%) and emotional problems (25%). Boredom, parental role models, and social pressures were each cited by 10.7% as causes. Over a third (36.1%) pointed to counseling as the best treatment, with community education well behind (14.8%).

The overwhelming **cause of drug abuse** was seen as peer pressure (36.6%). Both education (36.4%) and counseling (30.8%) were recommended solutions to the problem. Police enforcement was suggested by 7.3% and traditonal guidance by 5.5%.

For Sahme, one of the most notable survey results was the confirmaton of a **natural care system** in the community. When asked where they go for advice, 59.6% of the respondents said they go to a friend or relative, primarily because of the trust and understanding they feel they can count on. Only 10% said they utilized organized programs. And 59.2% felt that people should rely more on themselves.

Alcoholism — A nutritional wasteland

(Reprinted from NIHB Health Reporter)

Alcoholism and alcohol-related deaths are widely recognized as the number one killer of Indian people. In recognition of this frightening statistic and of the recent second National American Indian School on Alcohol and Drug Abuse, we offer the following discussion of Nutrition and the American Indian Alcoholic by Dr. Alan Ackerman.

Dr. Ackerman is a nutrition expert working with the Navajo Tribe. As a science for citizens resident funded by the National Science Foundation, Dr. Ackerman states that the opinions expressed are his own and do not necessarily reflect the views of the National Science Foundation. Nutrition and the Alcoholic.

Alcohol is not a nutrient, but it does contain calories. Two ounces of 100 proof whiskey contain about 170 of them. A male adult alcoholic who drinks a pint of whiskey a day gets about half of his needed food energy (calories) from the booze. But unfortunately for the alcoholic, the alcohol contains no nutrients, vitamins, minerals or protein. There, a person deriving half of their calories from alcohol must get 100 per cent of their nutrient needs from the other 50 per cent of their diet; not an easy task.

So, what problems arise when an alcohol consumes half or more of their calories from alcohol (be it wine or hard liquor, it makes no difference nutritionally)? For one thing, ethanol, the alcohol in whiskey, wine or beer, is toxic to the liver when drunk in sufficient quantity for a long enough time. It is also known that poor nutrient intake makes the ethanol more toxic to the liver. So, the poor intake of nutrients coupled with the consumption of alcohol accelerates cirrhosis of the liver.

In summary, the likelihood of an alocholic, whether he or she is a binge drinker or a chronic alcoholic, to be malnourished is quite high. About 20 per cent of alcoholics in the general population show a mild form of malnutrition and 3 per cent show full-blown malnutrition.

Policy and Action Implications for Alcoholism Treatment and Detoxification

A number of the nutritional findings related to alcoholism and withdrawal should prove useful to Indian detoxification and alcoholism treatment centers. For their benefit, a summary is offered here.

If an alcoholic is malnourished prior to coming into a detoxification center, as is likely,the chances of cirrhosis having been promoted by the combination of alcohol intake and poor nutrition is high. The role of the detoxification center in terms of diet, needs to be focused on the following nutrients: protein, thiamin, niacin, riboflavin, pyridoxine, folic acid, magnesium, potassium and zinc. This means that these nutrients need to be present at least in the U.S. Recommended daily level. This can be accomplished either through food supplements or careful dietary planning by detox center staff.

Alcoholic protein deficiency is in one sense a milder form of the protein calorie malnutrition you may have seen in pictures of starving children. Its diagnosis is complicated by liver disorders in alcoholism (called diffuse hepatic fibrosis and cirrhosis and fatty liver). While there is ample evidence for damage due to lack of protein for the alcoholic, there is little evidence that large intakes of protein periodically are harmful and under medical guidance, a high protein diet is a traditional treatment for the hospitalized alcoholic during withdrawal.

Vitamins

Common deficiency syndromes are those of thiamin, riboflavin, niacin, pyridoxine, and folate. The only vitamin deficiency which is rare in a alcoholics is scurvey, or Vitamin C deficiency, presumably due to a change in the body chemistry from high alcohol intake.

Thiamin Deficiency: This is the most common clinical deficiency syndrome of alcoholic in the U.S. at present. Severe thiamin deficiency, called Von-Wernicke's syndrome, is a disorder which may lead to coma and death or to heart failure. Treatment with thiamin (vitamin B1) can prevent death in deficient individuals but they often continue to have memory loss and to be mentally disoriented.

(Continued on page 16)