THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

March 2004 **Volume 29 Number 3**

Cultural Practices and Beliefs of Birth and Death of Southwest Native American Tribes

Carol Dahozy, Area Nurse Consultant, Phoenix Area Indian Health Service, Phoenix, Arizona

All Native American tribes have cultural practices and beliefs surrounding the birth and death experience. These two events have significant meaning for every Native American tribe. Nurses working with Native American tribes are often directly involved in the care of patients at birth and at death. Cultural awareness of Native American traditional practices is important to the patient as well as to the nurse. According to Lillian Tom-Orme,[1] combining traditional beliefs with modern treatments not only provides culturally competent care but helps keep heritage alive.

Birth Practices

Native American cultures view children as a gift from the creator to be treasured, nurtured, and protected. This process begins during pregnancy for many Native American tribes. The Pima Indians are thought to be descendents of *HuHugam* meaning "those who are gone." They migrated to the Gila River Valley of Arizona around the year 300 B.C. and settled near the Gila River in the dry desert.[2]

Pima women were required to have their babies in a special segregation hut apart from the main dwelling. During labor an Indian woman was assisted by her female relatives or other women of her tribe who had special knowledge of birth customs.[3] The mother was instructed never to salt her food; the baby's navel would not heal properly if the mother used salt. When the baby was four days old, the godparents were to give the baby a name. The godmother would place a mixture of water and white clay into the baby's mouth to make certain evil spirits were kept away and lightning would not strike the baby as long as he or she lived. The baby was then presented to the first rays of the sun by his parents. The baby was placed in a cradleboard made of the bark of mesquite wood and cottonwood trees. The purpose of this early confinement was to give an early start for developing good sound nerves and obedience.[2]

The Maricopa migrated to their present location in the 1700s. They were originally a tribe of the Yumas of the Colorado River region. Their continual fighting with other Colorado River tribes caused them to move east where they settled with the peaceful Pimas along the Gila River.[2] One Maricopa Tribal member says she was told that babies are gifts and should not be mistreated. If you mistreat children, they would be taken away from you. She remembers that pregnant women were to stay away from animals or scary things. This could have negative effects on the baby, causing birth deformities. Mothers and grandmothers acted as the midwife and performed

In this Issue...

the deliveries. Pregnant women were also instructed to drink warm drinks and not to drink anything cold. After the baby was born, mothers were bound around their abdomen to help the involution process.

The Cocopah, Quechan, and Mohave tribes are referred to as the River Yuman tribes. They live on a series of reservations along the Colorado River near Parker and Yuma, Arizona. The Yuman Tribes believe that dreaming guided their people to special abilities affecting almost every phase of their lives.[4] All talents, skills, and achievements in life were believed to derive from dreams dreamed in the mother's womb. They have a special belief that the visions in the dreams are of the spirits of the great gods of the beginning of the world. The basic and most significant dreams are those which one had before birth, while still in the mother's womb. It is these prenatal dreams that the newborn baby and the child do not remember, but will come back to the growing boy and to the man as he grows older.[5]

The Hopi, which means good, peaceful, or wise, live in northeast Arizona. The Hopi people are one of the oldest tribes of the region. Mothers are often left alone at the moment of birth, but as soon as the baby is born, the maternal grandmother severs and ties the cord and makes her daughter and new grandchild comfortable. After washing the newborn, the baby is rubbed with ashes so its skin would always be smooth.

The baby begins its life on earth in a room almost as dark as the womb from which it has emerged. For eighteen days the mother and baby lay at rest in the darkened room. On the twentieth day the mother and baby are washed with the root of the yucca plant by female relatives. The baby is given a name by each female relative. The father stands watching for the sun. When the sun begins to appear, the grandmother carries the baby to the edge of the mesa. As the sun appears over the horizon, the grandmother lifts the baby so the sun rays fall directly on the little face. She sprinkles sacred corn meal over the baby while reciting a prayer. She flings the rest of the corn-meal over the edge of the mesa toward the sun. The baby is now a full member of the family. This ceremony is followed by a family breakfast feast.[3]

The Navajo Tribe believes that pregnancy is a natural state. A "Blessing Way" ceremony is conducted before the baby is born. The expectant woman is said to relive the creation story. The purpose of the ceremony is to promote a peaceful growth of the fetus and an uncomplicated delivery. Once birth has occurred, the Blessing Way provides immediate protection and strengthens the newborn's survival and coping skills. The ceremony also reinforces the bonding process of the new family.[6]

A Navajo woman must keep a peaceful and positive mind at all times as she communicates with her child in utero. She must tune into herself, feelings, thoughts, and experiences. She must avoid death, dying people, and funerals. She must not tie knots as in weaving or basket making. This could cause problems with the umbilical cord. The father of the baby must also keep good thoughts. He is responsible for protecting his mate's environment as well as her psyche.[6]

According to Wilson,[6] if there is a problem with the cord around the baby's neck, it can be treated by tying and untying knots over the woman's belly with a rope, yucca, or fern grasses. The placenta is given to the family and buried under a healthy bush or tree, giving back to mother earth. The umbilical cord is also buried with a special wish for the child. The first meconium stool is also saved and put on the mothers face to decrease pigmentation. The sash belt is wrapped around the mother's abdomen as a binder for two weeks after delivery to help with the involution process. Breastfeeding is the traditional choice. Freezing breast milk is taboo as it takes the life out of the milk. Babies are put into the Navajo cradleboard for security and protection.[6]

The Havasupai are a small band of the Yuman-speaking tribes who live in a deep canyon that forms a branch of the Grand Canyon. Havasupai means, "People of the blue water." They are closely related to the Hualapai tribe, and the two were once considered one tribe.[7]

The Havasupai believe that good health depends on using specific remedies and also observing taboos and carrying out prescribed behaviors for certain occasions.[8] The Havasupai believe that once conception takes place, certain precautions are necessary if the infant is to develop properly. According to Weber & Seaman,[8] mother and father have to avoid eating all meats one month before the baby is born and one month after the birth. The mother also must avoid salt before giving birth and through the nursing period. Using salt will cause things to dry up. The mother is not supposed to scratch her body with her fingers, but can use a stick to safely scratch herself.

When the time for delivery was near, the woman went home to her own mother. Her mother and female relatives assisted with the birth. If the baby was slow in coming, pressure was applied to the abdomen. The father may be asked to assist. The placenta was buried safely away from animals. A woven belt was wrapped tightly around the abdomen to force out the fluid; if this was not done, it was feared that fluid would flow to the top of the womb and cause death. Following the birth, the mother, baby, and father were bathed in yucca suds. The mother would lie down on a heated bed made by burying hot stones under moist stones. The mother was given hot soup made from dry corn. She was cared for in this manner for three nights.[8]

According to Weber & Seaman,[8] the baby was given the breast two days after birth. If the baby was a boy, the father would run every morning for the first month so that the boy

would grow up and chase deer. The baby was put in a cradleboard made by the baby's maternal grandmother before the child was born.

The Apache Tribe have a ceremony that has been passed down over many years. The Long-life Ceremony was given to them by the Apache Gods. It has been translated to mean "Water has been put on top of his head." This ceremony takes place as soon as possible after birth, before anything untoward can happen. This ceremony blesses and strengthens the baby. It is meant to carry the child safely until the puberty ceremony is held.[9]

The White Mountain Apache women also were attended by their female relatives. According to a tribal member, after the birth of the baby, the placenta is placed at the grandparent's house, as this is the place where they will find security and guidance. The woman is not to attend a funeral. Baby items should not be bought until after the baby is born. Pregnant women are not to go to Sunrise Dance ceremonies, where there is dressing of the yellow painted girl. Babies are also put into a cradleboard that is made of the pinon tree and Yucca plant.

Death Practices and Beliefs

Death is viewed by Native American Tribes as a natural part of life. It is a time of transition into another world. It is believed that at death the soul of the person continues the journey into an afterlife.

The Pima tradition begins immediately after one has died. As relatives prepare the body for burial, loud wailing accompanies their work, which is referred to as *ehsto* meaning, "to hide the remains."[2] The Pima's reverence for death was so great that mourners only say, "They have departed for the hereafter." The community gathers to help the grieving family. All the belongings of the deceased are buried with the body. The home is burned. Nothing remains to bring back memories of the departed one.

According to Shay,[2] the spirit hovers around their home for several days. Food is prepared and placed in the grave for the deceased to eat before their departure from the world. Family and mourners wail and sing the mourning songs. The name of the deceased is never mentioned again, as it is believed that this will bring sickness and death. There is a mourning period that lasts a month for family and friends. A widow had to cut her hair up to her earlobes. She cannot have a social life for a year.[2] The hereafter is referred to as *Si'al Wui,* "Where morning begins in the east." This is a place of everlasting merrymaking and dancing, and a place of only happy times.

The Yumans have a powerful and moving cremation ceremony. Singing and wailing preceded an imminent death. According to Griffin-Pierce,[4] mourners sang 30 song cycles with 200 songs in each. Men and women dance in line, arm in arm, moving back and forth to the accompaniment of the singing. Funeral orators made speeches praising the virtues of the deceased. The orators also addressed the dead, encouraging him to end his ties with his loved ones on earth.

Immediately after death, the body and all possessions, including his house, were set on fire. Mourners also cast their personal offerings on the fire. The River Yumans believe that the soul spends the first four days after cremation revisiting significant places in the individual's life.[4] During the four days after the funeral, relatives are to eat no meat, salt, or fish and drink no cold water. They fumigate themselves with the smoke of burning arrow weed. Female mourners cut their hair to ear level.

The Maricopa have beliefs similar to those of the Yuman Tribes. According to a tribal member, the Maricopa believe that their ancestors will come for them and help them make a peaceful crossing to the other side. The Maricopa also have cycles of songs that are sung at wakes and on the way to the crematory. Today, wakes are held in a community building referred to as a cry house. All the belongings of the deceased, including their animals, are burned or destroyed. Mourners also bring personal belonging to the crematory to be burned with the body. It is their belief that they send belongings on to someone that has died. After four days, the deceased must be forgotten. If you continue to remember the deceased, it will cause sickness and death.

The Hopi Tribe views life and death to be part of a continuous process. Life and death are viewed as a complementary pair that is part of a continuous whole. The Hopi believe that corn can be viewed as a metaphor of life itself. Hopis begin as seeds that are planted in the mother's womb. They emerge from the womb and are blessed by light and nourished by their family. On the 20th day, a Hopi child is led from the house where he/she has been kept and receives corn as the sun emerges from the eastern horizon. They grow and mature. Hopi live with corn as their mainstay of their diet. As adults they will create the seeds of the next generation and will eventually die and be replaced by their offspring. For Hopi, death becomes part of the cycle, and they will become katsina spirit essences.[10] They believe that the spirits of the dead become clouds that bring rain to the living.[4]

According to Rasband,[11] the hair of the deceased is washed in yucca suds and prayer feathers are placed in the hands, feet, and hair. Over the face is placed a mask of cotton that is representative of the cloud mask the spirit will wear when it returns with the cloud people to bring rain to the village. Women are wrapped in their wedding robes; men are buried in a special blanket with a plaid design.

The ghosts of the dead are feared rather than death itself. To prevent the ghosts from returning to bother the living, *pahos* are given to the spirits of the deceased, and the trail back to the village from the burial site is ceremonially closed with sacred meal. Those who did the actual burial are purified with juniper smoke. The spirits of children who die before they are initiated are believed to return to the mother's house to be born again.

The Navajo believe that when one dies, the spirit that represents the good in life goes to an afterworld. The journey takes four days and the spirit of the person is guided to the afterworld by deceased relatives and friends. The afterworld is

an underworld and is accessed through the "hole of emergence" from which the first Navajo people came forth at the beginning of time. The afterworld is like life on earth and the inhabitants live there the same as do the living Navajos, but it is a good life with happy times.[12]

According to Alvord,[13] when a person dies, the "good" part of the person leaves with the spirit, while the "evil" part stays with the physical body. When a person dies, an evil spirit referred to as "*ch'iindi***"** is released with the last dying breath. The *ch'iindi* is considered very dangerous and causes sickness and misfortune. The Navajo are very fearful of the *ch'iindi* and take every precaution to avoid contact. They take great caution to avoid the dead, graves, and anything connected with death. When a person dies in a hogan, the hogan is destroyed.[13] Even today, families will bring their dying relatives to the hospital to prevent them from dying in the home. Many Navajos will avoid hospitals as they feel the buildings are filled with *ch'iindis*. One who has touched a dead body must undergo a ceremony known as the Enemy Way to purify and release the *ch'iindi* spirit.

The Havasupai have beliefs similar to other tribes. They believe that a person's ghost could cause sickness and death. Therefore, everything must be done to remove the dead, his belongings, and anything that would cause people to remember him. Remembering and speaking of the deceased person would cause his spirit to return. The funeral was based upon the destructive and purifying power of fire.[8] At the time of death the body and personal belongings of the dead person were burned. The person's home was burned, animals were killed, and crops were destroyed. During the burial process, songs were sung and the person's life and good deeds were retold and reenacted.

According to Weber & Seaman,[8] the Havasupai abandoned cremation and began burying their dead. The Havasupai believed that a corpse could arise with greater ease from beneath a pile of stones than from ashes scattered by wind and rain. It is also thought that the change was due to pressures from Christian missionaries and other outside pressures.

The Havasupai adopted the Yuman Tribes mourning ritual. A gathering referred to as *Nemitiawak* meaning "meet to cry" is held. Mourning songs are sung and the people form a circle and dance to the songs. During this time, the people are allowed to talk about their loved ones who have died. They bring gifts to send to their loved ones who have gone to the spirit world. These gifts are cast into the burning fire. The ceremony is followed by a feast for all in attendance. This ritual is held on an annual basis allowing tribal members to laugh, to weep, to dance and to sing.[7]

The Apache Tribe believes that when a person dies, a dead kinsman appears to the dying to lead the person on a four-day journey to the north where the afterworld is located. All his possessions are destroyed so they do not stand in the way of the deceased one's path to the Spirit World. The name is never again spoken or mentioned after death. The Apache ritual places the head facing in an Eastward direction with the feet toward the west. Female relatives conduct lamentations and crying loudly at sunset. This practice is often conducted at the patient's hospital bedside. Widows used to cut off their hair, and she lived with the family of her husband's brother whom she married at the end of the mourning period.[4]

Conclusion

Native Americans tribes view birth and death with very specific meaning. Many of these cultural beliefs are still practiced today. Cultural awareness of these sacred events is important for nurses to provide quality culturally sensitive care to Native people.

References

1. Cantore J. (01, February 14). *Earth, Wind, Fire and Water*. Retrieved November 19, 2003, from *http://www.minoritynurse.com/features/nurse_emp/01-14-02b.html*.
2. Shaw AM (1974). *A Pima Past* (3rd ed.). Tucson: The University of Arizona Press.
3. Niethammer C. (1997). The dawn of life childbirth in Native America. In C. Niethammer (Ed.), *Daughters of the earth, the lives and legends of American Indian women* (pp. 1-21). New York: Touchstone.
4. Griffin-Pierce T. (2000). The River Yumans. In T. Griffen-Pierce (Ed.), *Native peoples of the southwest* (1st ed., pp. 233-259). Albuquerque, NM: University of New Mexico Press.
5. Desert Southwest Transmission Line (2003). Cultural Resourses. *Desert Southwest Transmission Line*, 3.2-10.
6. Wilson U. (1999). *Navajo Cultural Beliefs*. Retrieved December 29, 2003, from *http://www.delphicenter.org/library.htm.*
7. Iliff FG. (1985). Foreward. In F. Iliff (Ed.), *People of the Blue Water* (2nd ed., pp. 10-15). Tucson,AZ: University of Arizona Press.
8. Weber S, Seaman P. (1985). Maintaining a healthy family. In S. Weber (Ed.), *Havasupai Habitat* (pp. 106-117). Tucson, AZ: University of Arizona Press.
9. Kavasch E, Baar K. (1999). Birth and Infancy. In E. Kavasch & K. Barr (Eds.), *American Indian Healing Arts* (pp. 2-15). New York: Bantam Books.
10. Geertz C. (2003). *Hopi World View*. Retrieved November 14, 2003, from *http://mc.maricopa.edu/dept/d10/asb/anthro2003/religion /hopi_world_view.html*.
11. Rasband J. (2001). *Rituals and rites of passage*. Retrieved November 14, 2003, from *http://teacherlink.ed.asu.edu/tlresources/units /Byrnes_celebrations/rites%20of%20passage.html*.
12. Carter H. (1999). *Death or, is life worth leaving?* Retrieved November 13, 2004, from *http://www.hyattcarter.com/Death_or_,htm.*
13. Alvord LA (1999). *Cutting into sacred territory*. Retrieved November 13, 2003, from http://www.salon.com/health/books/1999/06/09/cadver/print.html.

A Case Presentation and Discussion

Daniel Berg, MD, Department of Internal Medicine, Gallup Indian Medical Center, Gallup, New Mexico

Chief Complaint

Fever and swollen joints for 10 days.

History of Present Illness

A 35 year-old man with no significant past medical history developed a sore throat one month before admission. He was treated at an outside service unit with a shot of penicillin at that time. His sore throat improved, but returned about ten days after receiving his shot. Of note, several of his children also had sore throats.

Eighteen days before presentation he developed a sore right heel. He then developed a rash behind the ankles and knees, and on the arms. He describes it as macular circular lesions with well demarcated edges and central clearing. The rash and heel pain resolved over the next week, but then ten days before presentation he developed joint pains in the ankles, knees, hands, wrists, and shoulders. His left hand became swollen and painful first, then resolved while his right hand swelled. The joint pains in his leg required him to use crutches for seven days before becoming completely bed bound for the three days up until arrival at GIMC.

He reported subjective fevers for one week, along with anorexia and vomiting. He also noted dark urine for two days. He denied diarrhea, penile discharge, or infidelity. He still had a sore throat on the day of admission. Rapid strep test in the emergency department was negative.

Past Medical History

None.

Medications

None.

Family History

Unremarkable.

Social History

Married with four children. Works in social services in Window Rock, Arizona. No tobacco or alcohol use.

Review of Systems

No weight loss, cough, hematuria, kidney stones, melena, or bright red blood per rectum.

Physical Examination

Vital Signs: T 97.3; P 86; R 18; BP 128/85. *Gen*: Young man in no distress. *HEENT*: jaundice. Oropharynx without erythema or exudate. No lymphadenopathy in neck, axillae, groin. Throat without erythema or exudate. *Lungs*: Clear to auscultation bilaterally. *CV*: Regular rate and rhythm without murmurs, rubs, or gallops. *Abd*: soft, nontender, not distended, with normal bowel sounds. *Ext*: no cyanosis, clubbing, or edema. *Joints*: swelling and erythema in right ankle and right knee with large effusion in knee. Right hand is swollen over the proximal interphalangeal and metacarpalphalangeal joints, as well as over the carpals and wrist. Shoulders very sore.

Laboratory

Knee arthrocentesis: 22,700 wbc's, 25,300 rbc's, 96% PMN's. Gram stain negative. *CBC*: wbc 28.8 with 90% neutrophils. Hgb 14.1; hct 40.8; platelets 402,000 *Hgba1c* 6.4%. *ESR* 106. *Urate* 2.9. *Sodium* 127. *Creatinine* 0.9. *AST* 54. *ALT* 107. *Alk Phos* 191. *Bilirubin* 4.4. *Protein* 8.7. *Albumin* 2.7. *RA panel* negative. *Urinalysis*: 100 protein, 33 rbc's, 6 wbc's. *Electrocardiogram*: first degree A-V block with pr interval 248. Labs pending at time of admission: ASO, throat cultures, ANA, hepatitis panel, urine gonococcus and chlamydia screens, HIV.

Assessment

At the time of presentation acute rheumatic fever was the leading diagnosis. Other possiblities considered included gonococcal arthritis, hepatitis C with cryoglobulinemia, reactive arthritis, or a new onset rheumatic disease such as RA or SLE.

Treatment

The patient was treated with claforan 1g iv q8, penicillin 500mg po tid and aspirin 2g po bid. He rapidly improved on this regimen. During his hospitalization he developed a new S3 gallop on cardiac exam, though he was asymptomatic. A troponin and BNP were normal. An echocardiogram was normal. The S3 disappeared on the day of discharge. His hyperbilirubinemia resolved with fluids and was attributed to Gilbert's disease. His ECG remained abnormal with a prolonged pr interval. His fevers resolved during hospitalization. An ID specialist and cardiologist consulted on the patient.

The patient was discharged after three days to complete seven days of penicillin and ciprofloxacin. He continued on aspirin 2g bid and a PPI for prophylaxis. After he left all labs came back negative except for the ASO, which was elevated at 1701.

One week after discharge the patient returned to clinic feeling much stronger. He could walk unassisted and felt that he was getting back to his baseline physical health. He was given 1.2 million units of benzathine penicillin IM and told to follow up three weeks later. His four children and wife were also tested. One child had asymptomatic streptococcal pharyngitis. All family members were given seven days of penicillin.

Review of Acute Rheumatic Fever

Acute rheumatic fever is an illness only rarely encountered at this time in the United States, although it is still common in the developing world. It principally occurs between the ages of five and 15 years, although it can occur at any age. Principal risk factors include crowding and low socioeconomic status.

It is an inflammatory disease occurring after pharyngeal infection with Group A Streptococcus, leading to fever, polyarthritis (sometime migratory), carditis, chorea, erythema marginatum, and subcutaneous nodules. Streptococcal infection at any other site will not cause disease.

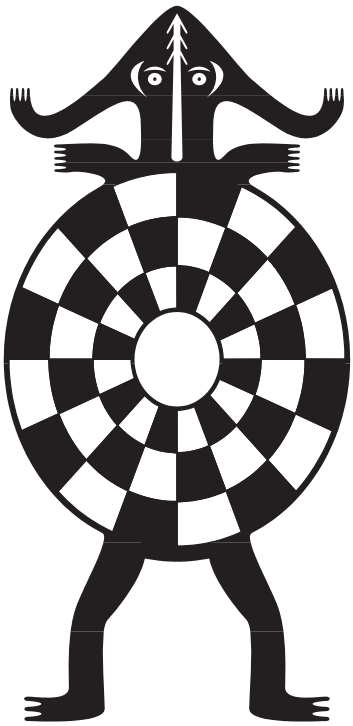
To qualify for the diagnosis, the patient must have evidence of preceding Group A streptococcal infection and meet two major criteria or one major and two minor criteria from the Modified Jones Criteria. The major manifestations are: carditis, polyarthritis, chorea, erythema marginatum and subcutaneous nodules. The minor manifestations are arthralgias, fever, elevated ESR or CRP and prolonged pr interval on ECG. Preceding streptococcal infection should be documented with a positive throat culture or elevated or rising streptococcal antibody titer. The patient discussed had three major criteria (carditis, polyarthritis and erythema marginatum) and four minor criteria with good evidence of preceding streptococcal infection.

Recommended treatment involves antibiotics and anti-inflammatory medications. 1.2 million units of benzathine penicillin and 4-8 grams of aspirin per day in divided doses is the standard therapy. Some experts advocate high dose glucocorticoids for severe carditis (prednisone at 2mg/kg/day), although there is not good evidence for this therapy. In this case we treated the patient with both penicillin and claforan since it was initially unclear whether or not the patient may have had disseminated gonococcus. He also received high dose aspirin.

In general, 75% of patients recover within six weeks, with 5% persisting greater than six months. Salicylate therapy should continue until after the ESR has normalized. Recurrences generally only occur with reinfection, though patients who have had rheumatic fever are very susceptible to recurrence with reinfection and therefore require long term antibiotic prophylaxis with 1.2 million units of benzathine penicillin per month. Length of treatment is controversial; while patients should be treated for a minimum of five years, some advocate ten years or even lifelong therapy.

References

1. Essential Cardiology, W.B. Saunders Company 2001, 561-564.
2. Harrison's Principles of Internal Medicine, Thirteenth Edition, McGraw-Hill 1994, pg1046-1052.
3. UpToDate, Feb, 2004



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 2, No. 2, February 2004) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

News flash: NEW: NEONATAL RESUSCITATION PROGRAM at the ACOG/IHS Postgraduate course in Denver. The course will be held on Sunday morning, June 13th from 8 am to 12 noon at the Radisson Hotel. Class size for the NRP is limited, so please register early! The regular ACOG/IHS course begins at 1 pm that afternoon. More information can be found at *http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#June2004*, or see flyer on page 65

Abstract of the Month

Low-risk deliveries in a collaborative care birth center have outcomes similar to hospital deliveries by obstetricians.

Whether low-risk women give birth in collaborative care birth centers that use certified nurse-midwife (CNM)/obstetrician management or in a hospital where care is managed by an obstetrician, maternal and infant outcomes are similar. However, the collaborative care birth centers have fewer surgical deliveries and use fewer medical resources, according to a study supported in part by the Agency for Healthcare Research and Quality (HS07161).

William H. Swartz, MD, of the University of California, San Diego Medical School and his colleagues studied the care and outcomes of 2,957 low-risk, low-income women from the time they began prenatal care to discharge home from a collaborative care birth center or hospital. Of these women, 1,801 received collaborative care, and 1,149 received traditional hospital care. Major antepartum, intrapartum, and neonatal complications were similar in both groups, as were neonatal intensive care unit admissions. However, women in collaborative care had 15 percent more normal spontaneous vaginal deliveries, 23 percent fewer episiotomies, and 36 percent less use of epidural anesthesia.

Overall, technical interventions (for example, induction and augmentation of labor with oxytocin, episiotomies, and epidural use) were more common in traditional care and less technical interventions (walking, tub or shower use, and oral fluids) were more common in collaborative care. Also, collaborative care women had shorter lengths of stay in the birth facility, with 28 percent more being discharged before 24 hours, and almost 6 percent fewer having stays longer than 72 hours. Thus, operative deliveries and hospital stays, major determinants of the cost of perinatal care, were substantially reduced with collaborative care. The researchers conclude that managed care organizations, local and state governments, and obstetric providers may want to consider inclusion of collaborative management/birth center programs in their array of covered or offered services.

Reference

Outcomes, safety, and resource utilization in a collaborative care birth center program compared with traditional physician-based perinatal care. DJ Jackson, RN, MPH, DSc, JM Lang, PhD, ScD, et al. June 2003 *American Journal of Public Health* 93(6), pp 999-1006.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12773368&dopt=Abstract.

OB/GYN CCC Editorial comment:

As we deliver maternity care to the Indian health community, similar question frequently arise. At my facility or at the facilities that send patients to my facility, 1) How few infants can a facility safely deliver per year? 2) How few deliveries can providers and nurses provide safely on an ongoing basis? and 3) Do 'birthing centers' need to maintain the same credentials and regulatory criteria as a Level I maternity center?

This article confirms previous literature that has shown that low risk maternity care can be provided safely in a collaborative manner using careful triage guidelines while being willing to transport appropriate patients. See the June OB/GYN CCC Corner for a example in Indian country (Leeman, et al), which was the June Abstract of the Month, at *http://www.ihs.gov/medicalprograms/mch/m/mchdownloads/cccorner61903.doc*

As to the other questions, they are actively addressed in the IHS Biennial Women's Health and Maternal Child Health Meeting. The Biennial meeting will be held in Albuquerque,

NM, August 4-6, 2004. I encourage all providers and staff who provide care to female AI/AN to attend to help us sort those issues out. This year's theme is "Prevention in American Indian and Alaska Native Women," and there are remarkable, nationally recognized experts on the agenda. For more information, go to *http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*.

From Donald Clark, Albuquerque

Prevalence and correlates of mental disorders in Native American women in primary care.

Objectives: We examined the lifetime and the past-year prevalence and correlates of common mental disorders among American Indian and Alaska Native women who presented for primary care. *Conclusions:* There is a need for culturally appropriate mental health treatments and preventive services.

Reference

Duran B, Sanders M, et al. Prevalence and correlates of mental disorders among Native American women in primary care. Am J Public Health. 2004 Jan;94(1):71-7. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14713701&dopt=Abstract.*

OB/GYN CCC Editorial comment:

Many adult mental disorders in AI/AN women start with traumatic experiences in childhood and young adulthood related to child sexual abuse and domestic violence. We will address many issues in the Violence Against Native Women track of the 2004 Women's Health and MCH Indian Health Conference, August 4-6, 2004 in Albuquerque, NM. Specifically, Dr. Duran will be discussing the above finding at the Biennial meeting.

Gynecology

Continuous combination oral contraceptive pills to eliminate withdrawal bleeding:
A randomized trial.

Conclusion: Extension of the 28-day oral contraceptive cycle to continuous use with a low-estrogen dose combination oral contraceptive pill (OCP) resulted in significantly fewer bleeding days.

Reference

Miller L, Hughes JP. Continuous combination oral contraceptive pills to eliminate withdrawal bleeding: a randomized trial. Obstet Gynecol. 2003 Apr;101(4):653-61. *http://www.ihs.gov/MedicalPrograms/MCH/M/MCHfamPlng.asp.*

OB/GYN CCC Editorial comment:

The practice of continuous OCPs is now receiving a great deal more attention in the literature and from pharmaceutical representatives. Gynecologists have used continuous OCPs for years successfully for treatment of various conditions, e.g., endometriosis.

Monthly menses are actually somewhat of a modern contrivance. Not that long ago, our AI/AN patients were either lactating or childbearing for the majority of their reproductive years. Menses were much less frequent until the latter part of the 20th century.

Please recall as various vendors vie for your pharmaceutical budget that you can easily explain to your patient how to use a series standard 28 day OCPs packages on a continuous basis for 3-4 cycles and then have a menses. You can also use it as a good opportunity to reinforce patient education about other aspect of the use of OCPs, as well.

Child Health

Infant physical abuse in Alaska higher than expected.

The rate of fatal infant physical abuse in Alaska during the 7-year study period was 0.20 per 1,000 (or 20 per 100,000). In comparison, the National Center on Child Fatality Review data indicate that the rate for Alaska during the period 1993-1997 was 11.71 per 100,000, while the National Center for Injury Prevention and Control data indicate that the rate for the U.S. as a whole in the year 2000 was 9.07 per 100,000. Gessner BD, Moore M, Hamilton B, et al. 2004. The incidence of infant physical abuse in Alaska. Child Abuse & Neglect 28(1):9-23. More information about child abuse, injury prevention, and infant mortality prevention is available from the MCH Library's organizations lists at *http://www.mchlibrary.info/databases/orgmenu.html*

OB/GYN CCC Editorial comment:

Infant and child abuse may have sequelae long past the childhood years. Dr. Duran at the University of New Mexico has quantified some of the long term effects on AI/AN later in life (see prevalence and correlates of mental disorders in Native American women in primary care above). Dr. Duran and oth-

ers will discuss these and other issues related to domestic violence at the 2004 Womens's Health and MCH Biennial meeting.

Primary Care Listserv

The Primary Care Discussion Forum is one way to learn about and discuss best practices with national experts in an e-mail format.

The next topic, May 1, 2004, facilitated by Donna Perry, Adolescent Medicine, Chinle, Arizona, will be on the topic of Adolescent risk taking behaviors . . . a.k.a. "Sex drugs, and rock and roll." This will include discussion of methamphetamine (up to 15% AI youth in some IHS Areas have tried it), alcohol, and marijuana; driving while "high" or riding with someone who is; and not wearing seatbelts.

You can expect 20-30 total e-mail messages per topic, four times a year. Each discussion will last approximately 4-6 weeks. If that is too much e-mail for you, then don't subscribe, or just subscribe for those topics of special interest to your practice and then unsubscribe after that topic is closed out. When finished, the full discussions and a summary will be posted on the Primary Care Discussion Forum web page at *http://www.ihs.gov/MedicalPrograms/MCH/M/PCdiscForum.asp*.

It is easy to subscribe. Go to the following page and fill in your name, then hit search, then follow the instructions:
http://www.ihs.gov/generalweb/helpcenter/helpdesk/index.cfm?module=listserv&option=subscribe&newquery=1.
Or, contact Jason Crim at *jason.crim@mail.ihs.gov* to join the Primary Care listserv.

It is also easy to unsubscribe; go to this page and fill in your name, then follow the instructions:
http://www.ihs.gov/generalweb/helpcenter/helpdesk/index.cfm?module=listserv&option=unsubscribe&newquery=1

From your colleagues

From Terry Cullen: Healthcare Disparities: Unequal Treatment, One Year Later; Management of TB, STDs, HIV and Hepatitis C – Strategies for today's clinician

From Barbara Fine: Grant Writing Workshop: National Indian Women's Health Resource Center; "Falls During Pregnancy" March 12, Interactive Web Seminar

From Jim Galloway: Cardiovascular Disease Prevention in Women; Disparities in Premature Deaths from Heart Disease; Coronary Heart Disease in Women with Diabetes

From Sandra Haldane: CNMs – Needed in Afghanistan; SIDS International Conference

From Howard Hays: Towards an Electronic Patient Record in Fort Lauderdale, FL

From Maria Martinez: Advances in cervical cancer prevention – FREE CME

From Kelly Moore: Call to action: The escalating pandemics of obesity and lifestyle

From Chuck North: Strength of Recommendation Taxonomy (SORT): A Patient-Centered Approach to Grading Evidence in the Medical Literature

From Jon Perez: Elder Care Resources from the Division's February 2004 Newsletter

From Sharon Phelan: Know any pregnant AI women interested in quitting smoking?

From Jennifer Retsinas: American Indian, Alaska Native and Native Hawaiian Caucus

From Laura Shelby: Do you have policies and procedures on treatment of STDs? Challenges faced in STD management in Indian County; Insurance coverage among American Indians/Alaska Natives and Whites; Chlamydial Infections: Clinicians Guide

From Arnold Sperling: 4th year students: Sub Internship in OB/GYN Rosebud, S.D.

From Judy Thierry: Do you want to impact Indian Health MCH for decades to come? Office for Victims of Crime (OVC) Clearinghouse

Hot Topics

Obstetrics:

First-trimester screening protocol for Trisomies 18 and 21; Maternal morbid obesity in early pregnancy is strongly associated with pregnancy complications; Management of gestation hypertension-preeclampsia; Predicting failed trial of labor after primary cesarean delivery; Coverage for U. urealyticum improves cesarean prophylaxis; Using rectal Misoprostol in the third stage of labor; SARS and pregnancy: A case report; Health literacy and pregnancy preparedness in pregestational diabetes

Gynecology:

I just gained all this weight . . .. I wonder if it was 'the pill?'; Best kind of dressing to use on a surgical wound? If using HPV DNA testing, then consider this; New contraceptive options; Increasing adherence to Pap guidelines; Evaluation and management of hirsutism in women; 2004 National Women's Health Week celebration: May 9-15, 2004

Child Health:

Who are "fragile families" and what do we know about them? Soft drinks being sold in schools? What is up with soft drinks being sold in schools? Child passenger deaths involving drinking drivers; Low glycemic index diet as practice-based treatment for overweight children; Reducing the risk of SIDS in child care; Azithromycin for persistent or recurrent otitis media; Prevention and treatment of type 2 diabetes in children

Chronic Illness and Disease:

Screening for type 2 diabetes in adults; Strength training among adults aged greater than or equal to 65 years; Moderate intensity exercise works: RCT in overweight, sedentary women; Alaska Natives have a disproportionately high percentage of HIV; Cognitive behavior therapy vs. relaxation therapy for IBS; Do you have Medicaid patients who smoke? Prevalence of diabetes and impaired fasting glucose in adults

Features

AFP: POEMS - First-trimester screening protocol for Trisomies 18 and 21; Ultrasound alone does not diagnose PCOS

ACOG: Uterine artery embolization; Ethics of elective primary cesarean delivery

AHRQ: Web M + M - A pregnant woman arrives at the ED with severe abdominal pain; Total and supracervical hysterectomy: Surgical/clinical outcomes are similar; More aggressive treatment recommendations for women with diabetes; Reducing by at least half the incidence of false-positive mammogram readings; Home visits by a nurse-health advocate team can improve the outcomes

Breastfeeding: Lower rates of overweight among children who were breastfed for longer duration; Easy guide to breastfeeding for American Indian and Alaska Native Families

Domestic Violence: Screening for partner violence: Direct questioning or self-report?

Elder Care News: Routine screening for thyroid disease in adults?

Frequently asked questions: Why do patients' blood sugars go up so high after certain meals? How does the intensity of the exercise affect weight loss, etc? Are pharmacologic agents safe to use for smoking cessation in pregnancy?

Hormone Replacement Update: Nonhormonal alternatives for the treatment of hot flashes; Understanding the risks and benefits of hormone therapy

Information Technology: Domestic violence code for recording GPRA information

International Health: Overseas contraceptives with no active ingredients; Agencies to cut maternal feaths; British Medical Journal: Epidemiology for the uninitiated

MCH Alert: Contraceptive use within adolescents' first sexual relationships; An argument for EC: Unintended pregnancy despite a family planning referral

Medscape: Efficacy and tolerability of oral Zolmitriptan in menstrually associated migraine; Uterovaginal packing with rolled gauze in postpartum hemorrhage;

Office of Women's Health, CDC: West Nile Virus during pregnancy, Infant guidelines

Osteoporosis: Relative value of heel ultrasound in the diagnosis of osteoporosis

Patient Education: Fiber: How to increase fiber in your diet; Nutrition: choosing healthy, low-fat foods; Nutrition: tips for improving your health; Pelvic inflammatory disease: updated facts

Editor's Note: The following is excerpted from the monthly Notes from the Elder Care Initiative *that is published as an e-mail newsletter. Information about how to subscribe can be found below. We would appreciate your feedback about whether or not you will find a periodic digest of this publication printed in* The Provider *useful.*

Notes From The Elder Care Initiative

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Northampton, Massachusetts

What's New

The Urban Indian Health Institute (UIHI) of the Seattle Indian Health Board has released an IHS-funded study of the long term care needs and preferences of elders living in the Seattle urban area. The *Urban American Indian/Alaska Native Long Term Care Needs Assessment* may be the first comprehensive look at LTC needs of urban-living AI/AN elders.

Findings from the report include a strong preference for home- and community-based services and an associated low acceptance of facility-based care. There was an indication of significant need for case-management services. Preferences for AI/AN administered services were contingent; if all else was equal, respondents preferred Native programs and services, but quality, affordability, and access were key issues. Most of the respondents had lived in the urban setting for many years and most did not intend to return to reservation as they age. This report will assist the SIHB in their effort to serve their elder population and should help focus the attention of all of us on the needs of the nearly half of all AI/AN elders who live in the urban setting.

The report was compiled from a mix of focus group and survey data. The survey and data collection tools, developed by UIHI for this purpose, are available with training to other programs. For more information or an electronic copy of the report, contact the UIHI at (206) 324-9360 ext, 2113 or online at *www.uihi.org*

From the Literature

The U.S. Preventive Services Task Force (USPSTF) concludes the evidence is insufficient to recommend for or against routine screening for thyroid disease in adults.

Rating: I Recommendation.

Rationale: The USPSTF found fair evidence that the thyroid stimulating hormone (TSH) test can detect subclinical thyroid disease in people without symptoms of thyroid dysfunction, but poor evidence that treatment improves clinically important outcomes in adults with screen-detected thyroid disease.

Although the yield of screening is greater in certain high-risk groups (e.g., postpartum women, people with Down syndrome, and the elderly), the USPSTF found poor evidence that screening these groups leads to clinically important benefits. There is the potential for harm caused by false positive screening tests; however, the magnitude of harm is not known. There is good evidence that over treatment with levothyroxine occurs in a substantial proportion of patients, but the long-term harmful effects of over treatment are not known. As a result, the USPSTF could not determine the balance of benefits and harms of screening asymptomatic adults for thyroid disease.

Overtreatment with levothyroxine increases the risk of osteoporosis and atrial fibrillation in the elderly; this relationship is seen even within the normal range (lower TSH, higher rates of osteoporosis and atrial fibrillation). The literature supports targeting the TSH at high normal in the elderly on replacement therapy.

For updates on USPSTF recommendations, go to http://www.ahcpr.gov/clinic/gcpspu.htm.

Resources

The **Center to Advance Palliative Care (CAPC)** is dedicated to increasing the availability of quality palliative care services in hospitals and other health care settings for people with life-threatening illnesses, their families, and caregivers. A national initiative supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by the Mount Sinai School of Medicine (NY), CAPC provides health care professionals with the tools, training, and technical assistance necessary to start and sustain successful palliative care programs.

Find the excellent online resources of the **CAPC** at *www.capcmssm.org*.

Constipation

The following article is another in an ongoing series in support of the development of a unified approach to palliative care services for American Indians and Alaska Natives. The series consists of brief, concise facts and information for providers of palliative care.

Judith A. Kitzes, MD, MPH, Soros Foundation, Project on Death In America Faculty Scholar, University of New Mexico Health Science Center, School of Medicine, Albuquerque, New Mexico

Chronic constipation: prevalence rate up to 30% in elders, and higher near the end of life.

The hand that writes for opioids must also write for a bowel regimen.

Diarrhea may be sign of impaction.

Constipation is a subjective term relating to the evacuation of hard stools less frequently than "normal" for an individual.

Causes	Symptoms
Malnutrition: autonomic neuropathy	Irregular bowel movements
Drugs (e.g., opioids, diuretics, iron)	Diarrhea
Poor fluid intake	Nausea/Vomiting
Decreased mobility	Abdominal discomfort
Abdominal tumors	Bowel obstruction
Hypo/hypercalcemia	Mental status changes

Treatment

1. Digital rectal exam: check for hard or soft consistency.
2. Increase fluid intake.
3. Start with bowel stimulant and softener:
   - Senna 1-2 tabs hs, plus docusate 100-240 mg PO bid
   - Titrate senna 2-4 tablets bid to qid , plus docosate 240 mg tid-qid
   - Take with lots of water
4. If no bowel movement in three days: Fleet enema or bisacodyl suppository rectally.
5. If still no bowel movement: consider mineral oil, or soapsuds enemas (caution in frail elders), or lactulose 15-30 ml PO qd to tid.
6. If rectum still full: digital impaction, may need to premedicate with opioid or midazolam.
7. If rectum empty: may need abdominal X-ray, and bowel obstruction management.

References

1. American Academy of Hospice and Palliative Medicine, Pocket Guide to Hospice/Palliative Medicine, 2003.
2. Kinzbruner B, Weinreb N, Policzer J. 20 Common Problems in End of Life Care, 2002.
3. Weissman, D. Fast Fact and Concepts #15

The Native Research Network: Promoting Culturally Sensitive Research in Indigenous Communities

The Native Research Network (NRN) is comprised of nearly one hundred persons involved in a broad spectrum of research ranging from the basic sciences to applied public health promotion programs. The NRN was created in 1997 as an informal network and has evolved into a non-profit 501 (c) 3 organization. The purpose of NRN is to establish and maintain a proactive research network of indigenous people of the Americas and to promote research among indigenous populations that is conducted in a culturally sensitive and respectful manner. The NRN provides networking and mentoring opportunities, a forum in which to share research expertise, sponsorship of research events, assistance to communities and tribes, and enhanced research communication.

The NRN is governed by an eleven-member Board of Directors elected by the NRN membership, and is administratively located at the Association of American Indian Physicians (AAIP) offices in Oklahoma City, Oklahoma. Funding for the NRN has been provided through a grant from the Office of Minority Health (U.S. Department of Health and Human Services), the Agency for Healthcare Research and Quality, membership dues, and in-kind contributions of its members.

Past Projects

For the past few years, the NRN held membership meetings at the Indian Health Service (IHS) Research Conference and the American Public Health Association (APHA) Annual Conference in order to recruit new members, conduct board and/or membership business, and to create opportunities for Native American researchers to interact and network. These opportunities to meet and network serve an important role for many Native American researchers, since they are often the only person in their health program, organization, or school with a particular interest in Native research. Many important collaborative relationships and mentoring opportunities have occurred as a result of these meetings.

Members of the NRN conducted a continuing education institute entitled "Conducting Research in Native Communities" at the APHA Annual Meeting and the National Forum on Health Disparity Issues for American Indians and Alaska Natives (OMH) in Denver in 2002. The purpose of this forum was to educate researchers about the issues that need to be considered and processes that need to take place when conducting research in partnership with Native communities.

Current Initiatives: the 2004 Indian Health Service Research Conference

The NRN is actively involved in the planning of a special session at the upcoming IHS Research Conference to be held in May 2004. Day three of the conference (May 13) will highlight the work and research activities of NRN members. The annual Board meeting of NRN will be held during the IHS research conference as well.

Current Board

Marla Pardilla (*Dinè*) Co-Chair
Leslie Randall (*Nez Perce*) Co-Chair
Tassy Parker (*Seneca*) Co-Chair Elect
Yvette Roubideaux (*Rosebud Sioux*) Co-Chair Elect
Donald Warne (*Oglala Lakota*) Secretary-Treasurer
Linda Arviso-Miller (*Navajo*) Board Member at Large
Thomas Ball (*Klamath*) Board Member at Large
Kelly Gonzales (*Cherokee*) Board Member at Large
Delight Satter (*Umpqua/Klickitat*), Board Member at Large
Lillian Tom-Orme (*Dinè*) Board Member at Large
Nina Wampler, (*Eastern Band of Cherokee*) Board Member at Large

Membership

Membership is open to Native researchers and students (including those associated with research, such as Community Health Representatives and program staff), as well as non-Native persons who have conducted research in Native communities. NRN membership meetings are held twice per year, usually in conjunction with the annual IHS Research Conference and with the annual APHA conference.

Membership Benefits

Membership in the NRN provides many benefits and opportunities, including:

- Networking with other Native researchers
- Collaborating with individuals and organizations
- Improved communication (including remote and rural areas) with other researchers
- Sharing grant opportunities
- Sharing job opportunities
- Provides a forum for Native professionals to review and critique each other's work in a safe and

supportive manner
- Mentoring for students and young research professionals
- Training opportunities to enhance skills
- Disseminating and acquiring American Indian/Alaska Native health information quickly
- Access to the NRN electronic listserv
- Finding people; on the listserv, people use their social networks to find colleagues who have moved, who have similar research interests, etc.
- Influencing research agenda-setting and policy development

Eligibility Criteria for Membership

- *Full Membership.* Any self-identified American Indian, Alaska Native or Aboriginal person native to the Americas, who is involved in research in any of the basic sciences, public health, interventions, survey administration, bench science, and including program/intervention efforts. These members would be fully paid, active members of the Full Member category. The five sub-categories are:
  1. Student (i.e., full-time, working on a degree program)
  2. Fellow/Intern/Post-doctoral
  3. Community Health Representative (CHR)
  4. Elder
  5. Professional

  Only Full Members are eligible to vote and to hold the position of Chair or Co-chair of the NRN.

- *Affiliate Membership.* Any indigenous person involved in research from Samoa, other Pacific Islands, Australia, New Zealand and Siberia. Affiliate Members are not eligible to vote, but they do have access to the other benefits of membership.

- *Treasured Friend.* Any non-indigenous person involved in research in American Indian, Alaska Native or aboriginal communities/populations native to the Americas. Treasured Friends are not eligible to vote, but they do have access to the other benefits of membership. To join as a treasured friend, the applicant is required to have sponsorship by a Full Member in good standing, and a letter of support from an AI/AN or aboriginal community in which they have worked.

To apply for membership or for more information about the Native Research Network, please visit the Association of American Indian Physicians website at *www.aaip.com* and click on the NRN link, or write to AAIP, 1225 Sovereign Row, Suite 103, Oklahoma City, Oklahoma 73108.

The 9th Annual Elders Issue

The May 2004 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the ninth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

New 2nd Edition Pediatric Environmental Health Available Free of Charge to Fellows

The American Academy of Pediatrics has produced a 2nd edition of *Pediatric Environmental Health*. Edited by Ruth A. Etzel, MD, the 700-page handbook features more than 40 chapters on identification, prevention, and treatment of childhood environmental health problems. Topics include strategies to reduce asthma triggers in the environment, prevent exposure to nitrates and methemoglobinemia in infants, and reduce exposure to pesticides. New chapters cover arsenic, gasoline and its additives, irradiation of food, metals (including chromium, manganese, and nickel), chemical- biological terrorism, and environmental threats to children s health in developing countries. Each chapter includes a list of frequently asked questions and responses, which makes this a handy desk reference for the busy clinician. All Fellows of the American Academy of Pediatrics may request a copy free of charge. To order, visit AAP s website at *http://www.aap.org/bookstore* or call (888) 227-1770.

CME Opportunity

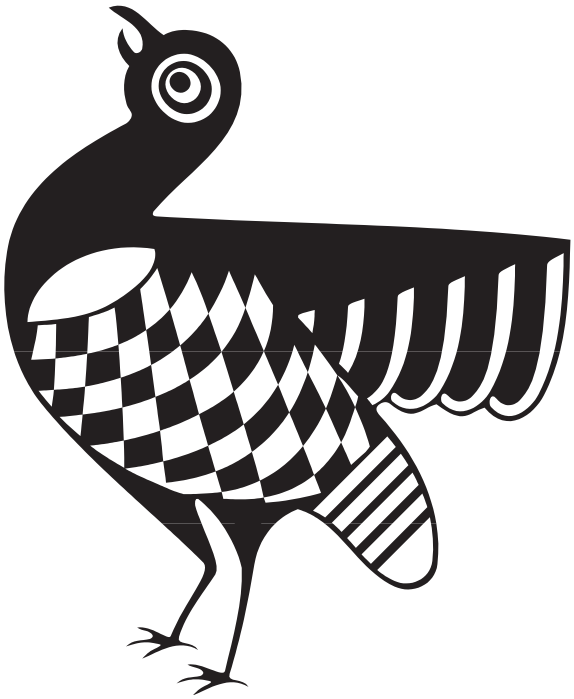
Lifecycle Of Type 2 Diabetes: Reducing Macrovascular Risk In Native Americans

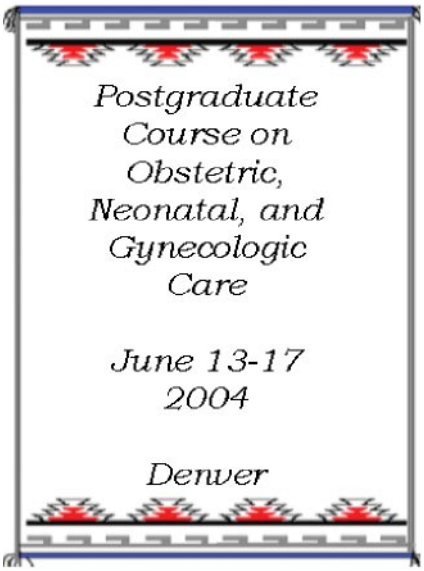
Joslin Diabetes Center Continuing Medical Education presents "Lifecycle of Type 2 Diabetes: Reducing Macrovascular Risk in Native Americans," an Internet-based, self-study CME activity for primary care physicians and other clinicians who treat Native Americans with diabetes.

The activity examines diabetes epidemiology and associated comorbidities that interact with culture and lifestyle; reviews the connection between diabetes and macrovascular complications; and instructs how to identify patients at risk for the metabolic syndrome, how to recognize and treat associated risk factors within Native American populations, and how to design and initiate appropriate risk management strategies for patients at all stages of the disease process. Faculty includes participants from Harvard Medical School, Joslin Diabetes Center, Indian Health Service, and the University of Arizona.

The Joslin Diabetes Center designates this educational activity for a maximum of 3.0 category 1 credits toward the AMA Physician's Recognition Award. The date of release for this activity was November 1, 2003, with expiration October 31, 2004. This activity is supported by an unrestricted educational grant from Wyeth Pharmaceuticals.

To participate in this free activity, go to the Joslin Professional Education website at *www.ProfessionalEd.joslin.org* and locate this activity, "Lifecycle of Type 2 Diabetes: Reducing Macrovascular Risk in Native Americans," in the WebCME Activity listing. Click on either the course title or on **Register Now**. CME credit may be obtained online by completing the activity, scoring 70% or higher on the posttest, and completing the activity evaluation form. Health care professionals who do not collect CME credits can obtain a participation certificate. For further information, contact the Joslin Diabetes Center's Professional Education Office by e-mail at *cme@joslin.harvard.edu*, or call (888) 567-5460.





TARGET AUDIENCE

This course is directed to primary care providers, including physicians, clinical nurses, nurse practitioners, nurse midwives, and physician assistants caring for women and infants in Indian Health Service settings and tribally-operated health care facilities.

COURSE DESCRIPTION

The curriculum is designed to encourage a team approach to the care of women and their newborns, with a strong emphasis on the realities and limitations of care in the rural, isolated settings that are common to many Indian health facilities. The text gives a clinically-oriented approach to care in facilities where the nearest specialist may be 50 to 800 miles away. Like the course focus and text, the faculty for the course is experienced with care in the Indian health setting.

CONTINUING EDUCATION CREDIT

ACCME Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The American College of Obstetricians and Gynecologists (ACOG) and the Committee on American Indian Affairs and the Indian Health Service.

AMA CME Category 1 Credit and ACOG Cognate Credit

The American College of Obstetricians and Gynecologists (ACOG) designates this educational activity for a maximum of 32 category 1 credits toward the AMA Physician's Recognition Award and a maximum of 32 category 1 ACOG cognate credits. Each physician should claim only those credits that he/she actually spent in the activity.

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation, and designates this activity for 35.4 contact hours for nurses.

REGISTRATION

The number of participants for the course is limited. Tuition, travel, and per diem expenses are the responsibility of the attendee or the sponsoring Indian health program. Send your completed registration form to Teddra Penland, IHS Division of Clinical & Preventive Services, 801 Thompson Ave, Suite 300 Rockville, MD 20852 (phone: 301-443-1840; fax: 301-594-6213 or 6135).

POSTGRADUATE COURSE ON OBSTETRIC, NEONATAL, AND GYNECOLOGIC CARE

(Please type or print)

☐ PA ☐
☐ MD/DO ☐ RN
☐ NP ☐ Other_____

Name _____
Last **First**

Work Address _____

Home Address _____

Telephone (Work) (Home) (Fax)

Service unit/health facility name Social Security Number

Email Address:

Please register me for the postgraduate course to be held June 13-17, 2004. I have checked the appropriate registration boxes below: *

☐ IHS employee:
☐ Physician $325
☐ Other health professional $225
☐ Non-IHS employee:
☐ Physician $450
☐ Other health professional $350

* Employees of tribes that have not withdrawn their tribal shares should use the IHS scale. If you are uncertain of share status, verify with Barbara Fine at (301) 443-1840. Space is limited. Applications received after session is filled will be placed on alternate list. Do NOT send fee payment until notified of placement in course.

Executive Leadership Development Program Announces 2004 Dates

VISION

The Executive Leadership Development Program is the preferred premier leadership-training program for Indian health care professionals.

PURPOSE

To educate current and future leaders to continually improve the health status of Indian people.

MISSION

The Executive Leadership Development Program will be the recognized leader in education and support services for Indian health care systems through collaboration, partnerships and alliances.

Executive Leadership Development Program New Dates

ELDP collaborates with federal, tribal and urban Indian health care systems to develop and increase leadership and management skills. In addition, participants develop new relationships and networks with other executives within the Indian health care systems

SESSION DATES:

Session One – Aurora, CO
May 3-7, 2004

Session Two – Aurora, CO
June 21-25, 2004

Session Three – Aurora, CO
July 26-30, 2004

The IHS Clinical Support Center is an accredited sponsor.

Indian Health Service Clinical Support Center
Executive Leadership Development Coordinator
Indian Health Service, Clinical Support Center
Two Renaissance Square, Suite 780
40 N. Central Avenue, Phoenix, Arizona 85004-4424
Phone: (602) 364-7777 FAX: (602) 364-7788
Internet: *ELDP@mail.ihs.gov*
Website: www.ihs.gov/nonmedicalprograms/eldp

NCME VIDEOTAPES AVAILABLE

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider *on a regular basis.*

NCME #823

Tuberculosis in the Workplace and in the Community (60 minutes) The role of the primary care physician in the early detection, diagnosis, and treatment of tuberculosis in patients without HIV infection. Although tuberculosis (TB) rates in the United States are at historic lows, TB still occurs each year in health care institutions, nursing homes, assisted-living facilities, schools, industrial sites, prisons, and other community settings. This program discusses the role of the primary care physician in the early detection and prompt treatment of TB in the community. It focuses on the non-HIV patient with active TB. Epidemiology, risk factors, symptoms, and transmission of TB are reviewed. Special attention is given to the diagnosis of active TB in foreign-born and native-born individuals who are at high risk for TB. Treatments for active and latent TB are summarized. Reliance upon directly observed therapy is stressed, as is the need for ongoing communication among general practitioners and local public health officials, especially in communities where the risk of TB is high. This telecourse is based at the New Jersey Medical School National Tuberculosis Center, one of the foremost TB clinics in the nation. Viewers are referred to website materials on TB assessment and patient care, published online by the New Jersey medical School National Tuberculosis Center (*www.umdnj.edu/ntbcweb*).

NCME #824

Managing End-of-Life Care *(60 minutes)* Helping a patient through the death process can be daunting and is rife with issues. In addition to medical challenges, there are religious/spiritual, emotional, ethical, financial, and legal matters to consider. The patient's spouse, family members, and close friends often look to the physician to coordinate these matters, and to provide guidance and support as the loved one's condition deteriorates. Dr. Larimore provides a comprehensive review of the physical and mental aspects of death and dying, and offers advice for helping patients and their families transition smoothly through the patient's end of life.

NCME #825

SARS Update: Preparing for a Possible Outbreak in the US *(50 minutes)* In this program, Dr. Michael Grey discusses steps that practitioners can take to prepare for and deal with a potential outbreak of severe acute respiratory syndrome (SARS). Dr. Grey summarizes the epidemiology and pathogenesis of SARS, and he discusses the differential diagnosis of this potentially fatal infectious disease within the context of two hypothetical cases. In the first, a patient presents with an atypical and rapidly progressing pneumonia of unknown origin; the patient is a strong candidate for SARS based on his risk factors (he has recently traveled to a SARS-endemic region of the world) and his clinical presentation. Conversely, in the second case, a patient with an upper respiratory infection is not a likely candidate for SARS because she lacks key elements for the typical SARS patient history and clinical presentation. Yet SARS must also be considered in her differential diagnosis. Laboratory and imaging tests to identify the SARS coronavirus are summarized. Dr. Grey discusses the importance of expediting sputum samples to a local health department or directly to the CDC. He reviews isolation and quarantine procedures that will be necessary if a SARS outbreak occurs, and he addresses palliative care for SARS patients. This telecourse also emphasizes the key role that general practitioners can play in calming patient apprehension about the onset of "normal" flu-like symptoms of SARS. Viewers are informed about CDC and WHO websites that provide SARS updates.

NCME #826

Identifying and Managing Depression *(60 minutes)* Depression is a pandemic problem, affecting all segments of our population regardless of age, race, or socioeconomic status. While brief bouts of depression are a normal part of living, major depression profoundly impairs a person's functional ability and costs our society millions of dollars in lost wages and health care utilization. Debilitating as it is, depression often goes unrecognized in the primary care setting. Dr.

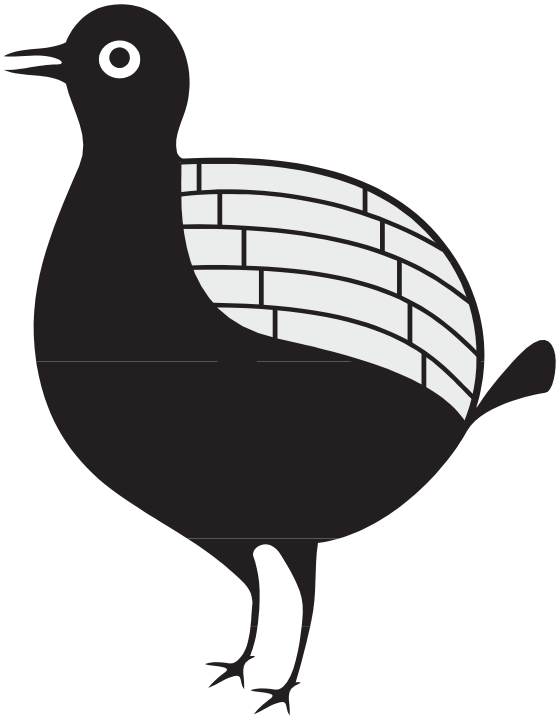
Deltito provides some background on depression and offers tips for clinically recognizing this common problem. He discusses the role of screening and reviews current treatments. Dr. Deltito also reviews depression in three special patient populations: children, new mothers, and those with seasonal affective disorder. The program concludes with case presentations that demonstrate how to evaluate depression in a clinical setting.

NCME #827

Sexually Transmitted Diseases, Excluding HIV/AIDS *(60 minutes)* Among industrialized countries, the United States has the highest prevalence and incidence rates of sexually transmitted diseases (STDs). It is estimated that each year approximately 15 million Americans acquire a new STD. Several STDs are notifiable infectious diseases that must be reported to the local health department: syphillis, gonorrhea, chlamydia, and chancroid. In addition, numerous other infections that are sexually transmitted require timely treatment and careful follow-up. It is essential that health care professionals communicate to their patients the importance of sexual health, STD prevention, and partner notification. The potential consequences and sequelae of untreated STDs can lead to long-term complications. Other STDs that are commonly encountered in the primary care setting in the United States are genital herpes; nongonococcal urethritis or cervicitis which can be caused by *Chlamydia trachomatis*; human papillomavirus (HPV) infection, which may manifest as genital warts or cause cervical squamous intraepithelial lesions and cervical cancer; and pelvic inflammatory disease, or PID. Dr. Harry Adams discusses STDs from a syndromic perspective by considering a series of case studies. Clinical presentation and examination, diagnosis, treatment, and follow-up of each case provide insights into the challenges physicians face in the clinical management of their STD patients.

NCME #828

Colorectal Cancer Screening, Management, and Prevention 2004 *(60 minutes)* Colorectal cancer is the second leading cause of cancer deaths for men and women in the United States. Screening methods are effective in reducing the incidence and mortality related to colorectal cancer. When discovered at an early stage, this disease is 90% curable. The American Cancer Society and other related organizations recommend colorectal cancer screening for asymptomatic adults over age 50. However, various reports indicate that less than half of these adults have been screened with fecal occult blood testing within the past year, or by flexible sigmoidoscopy or colonoscopy within the past five years. In this program, Dr. Rodney discusses the importance of starting the screening process at age 50 for average-risk patients and explains why the term "low-risk patients" is a misnomer. With the invaluable information provided in this program, primary care physicians will be able to incorporate effective screening and preventive strategies into the care of their patients.



POSITION VACANCIES ☐

Editor's note: As a service to our readers, The IHS Provider *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor,* The IHS Provider, *The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Staff Dentist
Registered Nurse
Toiyabe Indian Health Project; Bishop, California

Located in the beautiful Eastern Sierra region with year round outdoor activities. Hike the Sierras and ski at nearby Mammoth Mountain, plus many more activities in our rural area. Clean air, safe environment, excellent public and private schools. Great location for families with young children. Come join our team of dedicated professionals making an impact on the health of community members. We offer an excellent benefit package. Clinic hours are Monday through Friday, 8 am to 5 pm; no weekends or nights. We are desperately seeking a dentist with a current California dentistry license or willing to obtain, one year private or clinic practice, sensitivity to Indian traditions, customs, and socioeconomic needs.

Also seeking a nurse with a current California RN license or willing to obtain. Prefer clinical experience. Under the supervision of a physician, will direct daily patient care activities, making assignments for patient care under treatment plans, assure plans are followed, flow of care is efficient, and record keeping is accurate. Assume triage duties as well as administrative duties such as developing/updating policies; may supervise other medical staff.

Deadline for both positions: open until filled. Contact Personnel, 52 TuSu Lane, Bishop, California 93514; telephone (760) 873-8464; fax (760) 873-3935; e-mail: *bcoons@crihb.ihs.gov* for more information; or mail/fax your resume. Toiyabe is an EOE within the confines of the Indian Preference Act.

Pharmacy Director/Pharmacist in Charge
K'imaw Medical Center (KMC), Hoopa Valley Tribe; Hoopa, California

KMC is seeking a qualified individual to manage KMC's Pharmacy Services. Candidates must be registered and licensed with the California State Board of Pharmacy. This is a full-time contracted position located within the beautiful mountain valleys where you will find clean air, beautiful rivers, pristine lakes, excellent fishing, and other outdoor sports and recreation. Hoopa is located just six hours north of San Francisco, three hours northwest of Redding, and one hour northeast of Eureka in rural northern California; view the Hoopa Tribe's web page at *http://www.hoopa/*, or *www.hoopa-nsn.gov*. Benefits include excellent salary (DOE); relocation; 401(K); health, vision, dental, and life insurance; and twelve paid holidays. CPR Certification and ability to communicate with clients, health professionals, employees, and the general public are required. Knowledge of JCAHO accreditation standards and administrative experience are desired. Housing available at reasonable rates, with schools, library, and athletic facilities nearby.

For more information call KMC at (530) 625-4261, ext. 226. Send resume to KMC Human Resource Department, P.O. Box 1288, Hoopa, California 95546 or to *jmatilton@hotmail.com*. Open until filled. Selection will be pursuant to the Hoopa Tribe's TERO Ordinance. Applicant selected will be subject to pre-employment and random alcohol and drug testing.

Compliance Officer
Tanana Chiefs; Fairbanks, Alaska

The incumbent plans, designs, implements, and maintains an organization-wide compliance program and evaluates areas of corporate risk. He or she ensures the Executive Board, CAO, management, and employees are in compliance with the rules and regulations of state and Federal agencies; that company policies and procedures are being followed; that management and staff are sufficiently informed, trained, and educated; and that business practices in the organization meets ethical standards. The incumbent will provide assistance and guidance when directing compliance issues to the appropriate resources for investigation and resolution.

A Bachelors Degree in business or other related administrative field required; a Masters Degree in business or other related field preferred. Current knowledge of corporate compliance laws, directives, and any additional related laws. Working knowledge of HIPPA and similar compliance systems. Minimum of two years experience in the health care industry, with specific ethics/compliance program experience or legal experience. Working knowledge of Centers for Medicare and Medicaid Services (CMS) billing practices. Detailed understanding of government requirements/expectations for health care compliance programs. Demonstrated effectiveness operating in complex organizational environments. Excellent written, oral, and presentation communication skills, with ability and desire to communicate and maintain the compliance plan.

Proven ability to work with diversified levels of employees (management, boards, and staff). Strong problem solving skills. Demonstrated ability to partner effectively with others in handling complex issues. Sound business judgment.

Please submit Tanana Chiefs Conference application, resume, and references to Tanana Chiefs Conference, Employment Department, 122 1st Avenue, Suite 600, Fairbanks, Alaska 99701; e-mail *employment@tananachiefs.org*. Tanana Chiefs Conference is an equal opportunity employer; M/F/D/V and exercising Indian Preference pursuant to P.L. 93-638.

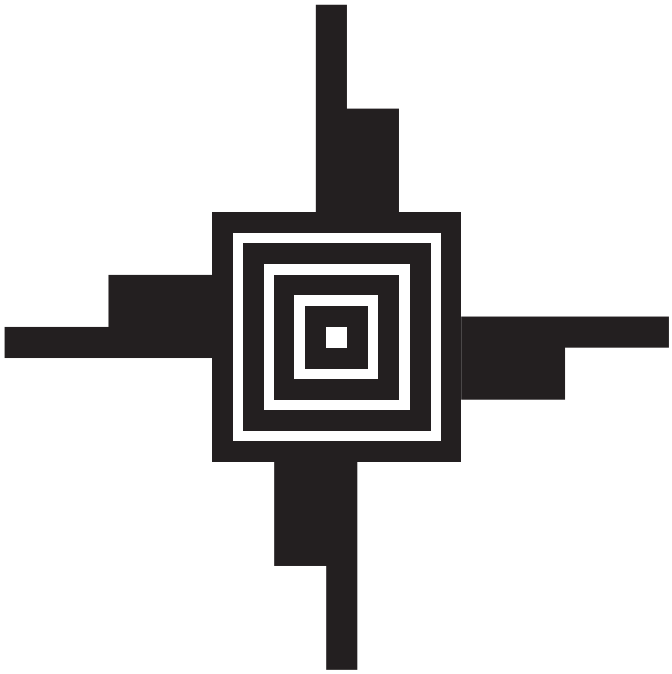
Health Information Management Director and Health Systems Specialist/Business Office Manager
Whiteriver Service Unit; Whiteriver, Arizona

The Whiteriver Service Unit is looking for highly motivated, progressive thinking, action-oriented people. We want to maximize our collections, use our resources efficiently, be on the leading edge of technology (PCC+, electronic medical record), and establish long-term goals that solidify our organization's future.

The Whiteriver Service Unit includes a 40-bed hospital and an ambulatory clinic in Cibecue about 40 miles away. We are a JCAHO accredited Critical Access Hospital, and have just completed our survey process with a score in the high 90s. Whiteriver is a very progressive service unit. It is well staffed and has been successful in generating third party revenue.

Whiteriver is located in the heart of the White Mountains, on the Fort Apache Indian Reservation in the east-central part of Arizona. This is a beautiful, scenic area with lots of ponderosa pine forest, lakes and streams, a ski resort, and a tribal casino. If you love the outdoors – hiking, fishing, skiing, hunting, rafting, biking – this is the place for you! The people in "the valley" – Phoenix and Tucson – come here to get away from the heat in the summer. The Blue Ridge school district in Pinetop/Lakeside (20 miles away) is one of the top five school districts in the state of Arizona. Government housing is available.

Please contact one of the following people for additional information: Kay Tsouhlarakis, Acting HIM Director, telephone (928) 338-3570; Randy Haigh, Director, Professional Services, telephone (928) 338-5554; or Berlinda Hopper, Human Resources, telephone (928) 338-3559.



MEETINGS OF INTEREST ☐

Geriatric Certificate Program
March 13, 2004 and Multiple Subsequent Sessions; Albuquerque, New Mexico

The New Mexico Geriatric Education Center announces their Geriatric Certificate Program beginning on March 13th as the first of four 5 hours sessions covering geriatric topics. The certificate is 20 hours of core curriculum and 20 hours of elective workshops such as the Summer Geriatric Institute. The two sessions scheduled for spring are on March 13 and April 17, and two for fall are on September 18 and November 13, all in Albuquerque at the University of New Mexico Health Sciences Center. The fee for all four sessions is $245. If you miss any session you can pick up the next cycle. CME/CEUs will be available for the hours. Call the NMGEC for an application at (505) 272-4934.

Strategies for Today's Clinicians: Management of TB, HIV, STDs, and Hepatitis C at the Border
March 26 - 27, 2004; Yuma, Arizona

This 1 1/2 day free conference will provide an update on TB, HIV, STDs, and Hepatitis C, common infectious diseases that affect many patients in the U.S./Mexico border region. Starting at 4 pm on Friday, March 26, participants will hear keynote speakers on border issues and rapid HIV testing, followed by dinner, and an update on Hepatitis C management. Saturday's agenda will address both clinical and program/case management topics, including epidemiology; STD/HIV interaction and implications for prevention; HIV/STD risk assessment and sexual history taking; TB screening, diagnosis, and treatment; HIV clinical manifestations and management; an STD Overview, including syphilis, gonorrhea, chlamydia, and herpes, and a special talk entitled, "Focus on Teens: STDs, HIV and Communication Issues." More detailed information, including a listing of faculty and a course agenda, will be available online at *http://www.fcm.arizona.edu/azaetc/Programs.html*.
Lunch will be served on Saturday.

The target audience include physicians, advance practice nurses, physician assistants, registered nurses, public health nurses, mental health providers, case managers, and other interested health care providers working in the Yuma, Arizona or Imperial County, California regions. CME credits and nursing CEUs will be provided through the Francis J. Curry National TB Center.

This activity is cosponsored by the Arizona AIDS Education and Training Center (AZ AETC), the Arizona Department of Health Services, the Francis J. Curry National Tuberculosis Center, and the California STD/HIV Prevention Training Center (CA PTC). There is no fee for this training; however, pre-registration is required. For more information and registration information, contact the Arizona AETC at *http://www.fcm.arizona.edu/azaetc/Programs.html*.

Navigating the New Medicare
April 3, 2004; The Tulsa Greenwood Cultural Center, 7200 N. Greenwood, Tulsa, Oklahoma
April 17, 2004; Southeast Expo Center, McAlester, Oklahoma

The Oklahoma State University Gerontology Institute, along with Pfizer Pharmaceuticals, AARP, Area Agency on Aging, Oklahoma Department of Human Services, and the Oklahoma State Insurance Commissioners Office are hosting informational forums throughout eastern Oklahoma for anyone interested in learning about the recent changes to Medicare. All forums will be held from 8:00 am to 12:00 noon, giving participants the chance to hear from experts in the field of Medicare. There will be a question and answer period for those who need specific information. There is no charge for any of the forums, and any questions about participation should be directed to the OSU Gerontology Institute at (405) 744-4945.

4th Annual Advances in Indian Health
April 21 – 23, 2004; Albuquerque, New Mexico

The 4th Annual Advances in Indian Health conference is offered for primary care physicians, nurses, and physician assistants who work with American Indian and Alaskan Native populations at federal, tribal, and urban sites. Medical students and residents who are interested in serving these populations are also welcome.

Both new and experienced attendees will learn about advances in clinical care specifically relevant to American Indian populations with an emphasis on southwestern tribes. Opportunities to learn from experienced career clinicians who are experts in native people's health will be emphasized. Indian Health Service chief clinical consultants and disease control program directors will be available for consultation and program development.

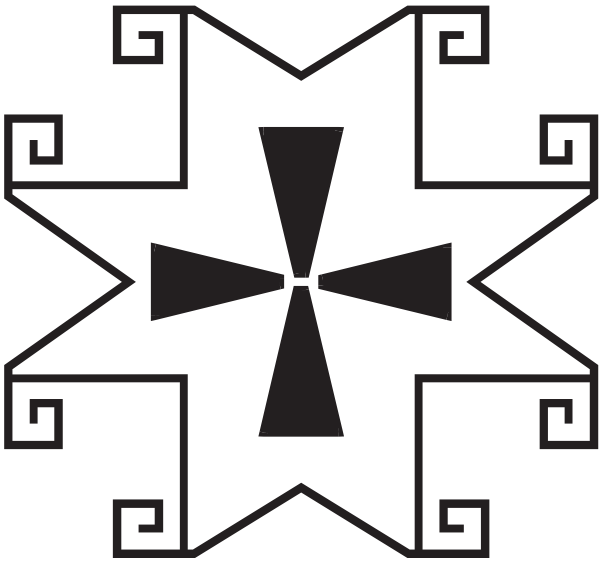
Hotel accommodations are at the Holiday Inn Mountain View Hotel, 2020 Menaul, NE, Albuquerque, NM 87107; telephone (505) 884-2511; fax: (505) 881-4806. All room rates are subject to state and local taxes, which currently total 10.8125%. The special conference room rates are $55.00 single or double occupancy; the deadline is April 7, 2004.

A Registration Form is posted on the University of New Mexico's CME website at *http://hsc.unm.edu/cme*. The conference brochure will be available in early March. To be on our mailing list, please call the Office of Continuing Medical Education at (505) 272-3942. The brochure will also be available, in February, on the UNM CME website at *http://hsc.unm.edu/cme*. For additional information please contact Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education at (505) 272-3942.

Panel on Indian Health at 2004 American College of Physicians (ACP) Annual Session
April 22 - 24, 2004; New Orleans, Louisiana

For the first time, the ACP Annual Session will include a panel devoted to Indian health entitled "The Changing Health Status of American Indians and Alaska Natives." The Annual Session is intended for all physicians involved in the practice of internal medicine. This includes general internists, subspecialists in internal medicine, family physicians, general practitioners, and residents and fellows in internal medicine and its subspecialties. Medical students and allied health professionals will find many sessions of interest and will benefit from the scope and depth of the program. There will be an opportunity for physicians from Indian health (I/T/U) to meet during the annual session.

For more information, call (800) 523-1546, ext. 2600; or visit the website at *www.acponline.org*.



2004 Primary Care Provider Training on Chemical Dependency
May 4 - 6, 2004; Phoenix, Arizona
August 10 - 12, 2004; Tacoma, Washington

This is a three-day intensive workshop that includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addictive medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 – 3 person teams from the same facility representing the various disciplines targeted). If selected, employees of P.L. 93-638 compacted or contracted tribal facilities that have taken tribal shares of the ASAPB and/or CSC will be charged a fee of $350 to attend and will be expected to provide for their own travel and per diem costs. For more information, please contact Colleen Good Bear, MSW, LCSW, Division of Behavioral Health, Headquarters, Rockville, Maryland; telephone (301) 443-2038; fax (301) 443-7623.

Office Based Opioid Treatment Course
May 7, 2004; Phoenix, Arizona
August 13, 2004; Tacoma, Washington

The IHS invites all physicians to register for its upcoming Office Based Opioid Treatment (OBOT) Course to be held on the Fridays following the above PCP training on chemical dependency mentioned above, in the same location. Physicians attending the PCP training may elect to stay over for the OBOT course.

The course faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians, including federal, state, and military.

For more information, contact Colleen Good Bear, MSW, LCSW at the numbers above.

National Environmental Health Association Annual Educational Conference
May 9 - 12, 2004; Anchorage, Alaska

The 68th Annual Educational Conference will feature a special session for providers on "Children's Health and the Environment" on Sunday, May 9 from 1 – 5 pm. Recent public recognition that children are different from adults in their susceptibility to environmental contaminants has resulted in a number of initiatives to protect this vulnerable group. In this session, information about environmental health risks to children will be presented, and prevention programs will be described. For further information, contact Ruth Etzel, MD, Alaska Native Medical Center; telephone (907) 729-3250; or e-mail *raetzel@anmc.org*.

16th Annual IHS Research Conference
May 11 - 13, 2004; Scottsdale, Arizona

The 16th Annual IHS National Research Conference, "MCH Research: Historic Reality and Future Hope," will enhance our ability to ensure benefits of research to Native communities and peoples. The conference will also examine in depth the impact of Women, Infant, and Children's research activity in American Indian and Alaska Native (AI/AN) communities. This three-day research conference will bring together many stakeholders in American Indian/Alaska Native research activities including clinicians, health administrators, educators, consumers, researchers, and community and tribal government leaders across the nation.

The IHS Research Conference will be held at the Doubletree La Posada Resort, 4949 East Lincoln Drive, Scottsdale, AZ 85253; telephone (602) 952-0420; fax (602) 852-0151; website *www.doubletree.com*. The conference room rate is $79.00 single/$88 double per room, per night, plus tax. Be sure to mention "IHS Research Conference" to receive this rate. Deadline for room reservations is April 7, 2004.

The conference is sponsored by the Indian Health Service and the IHS Clinical Support Center (the accredited sponsor). Individuals who want to present their research should prepare an abstract and fax, mail, or e-mail it (in Word format) to Leslie L. Randall, RN, MPH by April 2, 2004 (see Call For Papers). If mailing, include a diskette with the abstract in Word. E-mail addresses: *leslie.randall@ihs.gov* or *LHR6@cdc.gov*

For more information, contact Orie Platero, Conference Coordinator, 801 Thompson Avenue, TMP 450, Rockville, MD 20852; telephone (301) 443-1492; fax (301) 443-1522; or e- mail *oplatero@hqe.ihs.gov.*

Interdisciplinary Geriatric Seminar
May 13, 2004; Ft. Defiance, Arizona

The NM Geriatric Education Center will be holding an Interdisciplinary Geriatric Seminar on May 13, 2004 at Ft. Defiance Hospital from 8:00 am to 5:00 pm. Topics will include Geriatric Principles, Pharmacological Issues for the Elder, Types of Dementia and Challenging Behavior of those with Dementia, Oral Health and Systemic Disease, Oral Health Assessment in the home and long term care setting, and special cultural discussion of "A Culture of Three."

Call the NMGEC for registration at (505) 272-4934.

Sixth Annual American Indian Elders Conference
June 1 - 3, 2004; Oklahoma City, Oklahoma

The Sixth Annual American Indian Elders Conference, "Renewing the Spirit," will be held June 1-3, 2004 in Oklahoma City, Oklahoma. The conference will celebrate and honor the strong spirit of our elders as they willingly explore new pathways for better health and continuously set positive examples for generations to follow. Outstanding elders and their accomplishments will also be recognized, representing tribes throughout the state of Oklahoma.

Conference topics include health and wellness, cancer, diabetes, healthy cooking with commodities, arthritis, exercise, and fitness alternatives. The conference planning committee consists of representatives from Lawton Indian Hospital, Wewoka Indian Health Center, Oklahoma City Area Indian Health Service, the American Indian Institute, American Cancer Society, Cherokee Nation, Cheyenne and Arapaho Tribes, Choctaw Nation, Seminole Nation, Oklahoma Insurance Department, Department of Human Services' Aging Services Division, and the University of Oklahoma Health Science Center.

The conference will be held at the Biltmore Hotel, 401 S. Meridian Avenue (I-40 & Meridian), Oklahoma City, Oklahoma. A block of guest rooms has been set aside at a special lodging rate of $57.00. Make reservations before May 18, 2004 by calling (405) 947-7681 or (800) 522-6620. Registration brochures are now available. For more information on conference registration, exhibit/vendor space, conference support, or Outstanding Elder nominations, contact Ramona Wahpepah-Moore, e-mail *rwahpepah@ou.edu*; telephone (405) 325-6962; or Sue Fish, e-mail *sfish@ou.edu*; telephone (405) 325-4734 at the American Indian Institute; or K. Denise Smith, e-mail *karole.smith@mail.ihs.gov*; telephone (888) 275-4886, ext. 348 at Lawton Indian Hospital.

The IHS Southwest Regional Pharmacy Continuing Education Seminar
June 4 - 2004; Scottsdale, Arizona

The largest annual meeting of Public Health Service pharmacists and technicians, and pharmacists from tribally operated programs, this seminar provides up to 15 hours of ACPE approved pharmacy continuing education credit. Hosted by the IHS Phoenix, Navajo, Tucson, Albuquerque and California Areas and the California Rural Indian Health Board, the target audience is made up of pharmacists and technicians working in Indian health system pharmacies. For more information, contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at *edward.stein@mail.ihs.gov*.

The IHS Physician Assistant and Advanced Practice Nurse Annual CE Seminar
June 7 - 11, 2004; Scottsdale, Arizona

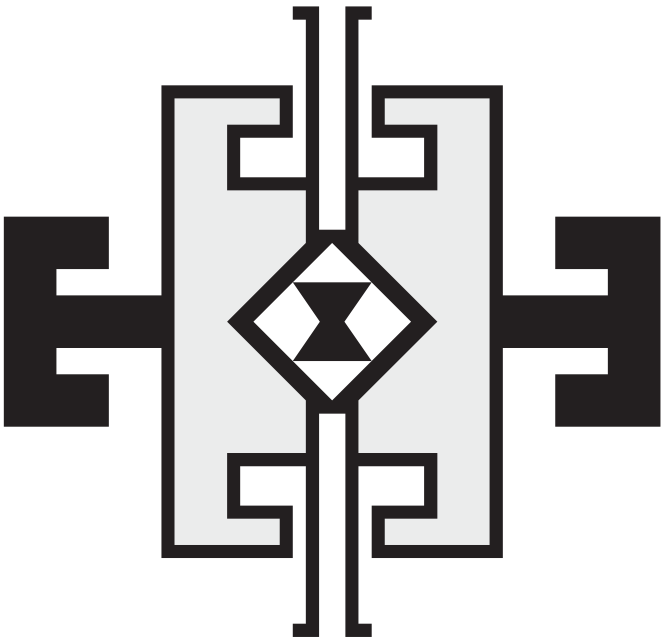
Designed for physician assistants, nurse practitioners, nurse midwives, and pharmacist practitioners working for Indian health programs, this three-day CE seminar will provide an opportunity to network with peers/colleagues on issues of common concern, update knowledge of current health trends and issues, develop new skills to improve patient care, and receive accredited continuing education. The program will offer approximately 20 hours of discipline specific continuing education designed to meet the needs of those providing primary care to American Indians and Alaska Natives.

The seminar will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258; telephone (480) 949-1414. Deadline for making room reservations is May 7, 2004. A business meeting for all Advanced Practice Nurses will be held Monday, June 7th through the morning of Tuesday, June 8th. The Physician Assistants' business meeting will be held Thursday evening, June 10th. The CE seminar will begin at 1:00 pm on Tuesday, June 8th and continue through noon on Friday, June 11th. The agenda will include both plenary sessions and concurrent workshops on a variety of clinical topics. The complete agenda and registration forms will be available by mid-April. A registration fee of $300 will apply for those employed by compacting tribes or those in the private sector. For more information, contact CDR Dora Bradley at the IHS Clinical Support Center, telephone (602) 364-7777, or e-mail *theodora.bradley@mail.ihs.gov*.

IHS National Council of Nurse Administrators (NCONA) Annual Meeting and Conference: *"Renewing the Spirit of Nursing"*
June 14 - 18, 2004; Prior Lake, Minnesota

IHS nurse administrators are encouraged to attend the annual NCONA Meeting and Conference to be held at the Mystic Lake Casino and Hotel, 2400 Mystic Lake Boulevard, Prior Lake, Minnesota; telephone (800) 262-7799. Make your room reservations by May 13, 2004. Be sure to mention the "IHS National Nurses Conference" when making your reservations.

Mountain Plains Health Consortium is the accredited sponsor for this meeting. More information about the conference will follow. Feel free to visit the NCONA web page for updates.



Summer 2004 Geriatric Institute
June 17 - 19, 2004; Albuquerque, New Mexico

This 2 1/2 day conference will focus on the Elder in Crisis: Managing Geriatric Emergencies, including the Elder with Fever, Abdominal Pain, Shortness of Breath, Acute Behavioral Disturbances, and Rehabilitation and Support for the Elder. Tuition waivers are available for IHS providers. There will be a Social Work Track and a CHR Track. CHRs in IHS Programs may apply for tuition waivers. The meeting will be held at the Santa Ana Star Casino Convention Center. Call the NMGEC at (505) 272-4934 for more information.

Women's Health and Maternity Care Biennial IHS, Tribal, and Urban (ITU) Meeting
August 4 - 6, 2004; Albuquerque, New Mexico

The biennial IHS, tribal, and urban (ITU) Women's Health and Maternity Care Meeting is offered for all physicians, nurses, nurse practitioners, nurse midwives, and physician assistants providing care at Indian health system facilities. Medical students and residents who are interested in serving these populations are also welcome. This year's theme is "Prevention and Health Promotion in Native Women."

Topics will include Domestic Violence; Internet Resources; The Postpartum Mom; Vaginal Birth after Cesarean; Breastfeeding and Type 2 DM Prevention; Syphilis Outbreak in the IHS - Lessons Learned; Urinary Incontinence; Infant Mortality; Hormone Replacement Risks; Prenatal Diagnosis; IUDs; Obesity in Early Childhood; and Breast and Cervical Cancer Screening.

The meeting will be held at the Holiday Inn Mountain View Hotel, 2020 Menaul, NE, Albuquerque, New Mexico 87107; telephone (505) 884-2511; fax (505) 881-4806. All room rates are subject to state and local taxes, which are currently 10.8125%. The special conference room rates are $55.00 Single or Double Occupancy. The deadline is July 21, 2004.

The registration fee will be payable by check, credit card, or institutional purchase order. The conference brochure will be available in early April. To be on our mailing list, please call the Office of Continuing Medical Education at (505) 272-3942. The brochure will also be available in April on the UNM CME website at *http://hsc.unm.edu/cme*. For additional information please contact the University of New Mexico Office of Continuing Medical Education at (505) 272-3942.

Sixth National Conference on Changing Patterns of Cancer in Native Communities
September 9 - 12, 2004; Phoenix, Arizona

Subtitled "Honoring Our Native Families from Prevention to Cure," this conference will focus on cancer epidemiology, control, and survival among Native populations. The goal is to evaluate progress in prevention of cancer in Native groups and in the early diagnosis, treatment, and survival of Native people diagnosed with cancer. The target audience for the conference will be community members, advocates, researchers, clinicians, and other health service providers working with Native populations: American Indians, Alaska Natives, American Samoans, and Native Hawaiians.

Featured topics will include Survivorship, Prevention, Early Detection and Screening, Cultural Sensitivity, Tobacco Issues, Traditional Diet, Men's Cancer Issues, Navigator System, Community Partnerships, and Understanding Cancer Statistics and Registries. Featured Speakers include Wilma Mankiller (Cherokee Nation); Dr. James Hampton (Medical Director, Troy and Dollie Smith Cancer Center); Charles Wiggins (Utah Cancer Registry); Linda Burhansstipanov (Native American Cancer Research; and Marc Heyison (Men Against Breast Cancer).

Hosted by Spirit of Eagles, the conference will be held at the Wild Horse Pass Resort and Spa. For more information, contact the conference planning committee at (877) 372-1617; e- *nativecircle@mayo.edu*; or visit the website at *www.mayo.edu/leadershipinitiative*.

2004 Conference on Health Care and Domestic Violence: Health Consequences Over the Lifespan
October 21 – 23, 2004; Boston, Massachusetts

The Family Violence Prevention Fund's (FVPF) National Health Resource Center on Domestic Violence's national conference on Health Care and Domestic Violence will be held October 21 – 23, 2004 in Boston, Massachusetts. This conference provides valuable professional education on the latest research and innovative health care prevention and clinical responses to domestic violence for all health care professionals, including physicians, dentists, nurses, physician assistants, dental hygienists, mental and behavioral health providers, social workers, researchers, domestic violence advocates, alternative health care providers, public health personnel, health care administrators, health policy makers, students, victims/survivors, and others.

The theme of the Third National Conference is *Health Care and Domestic Violence: Health Consequences Over the Lifespan.* Domestic Violence is a health care issue of epidemic proportions in the United States. In addition to posing immediate, acute health consequences, intimate partner violence (IPV) is a significant factor for poor health behaviors that can lead to chronic health problems. Many victims will see a health care provider for regular exams, specific health problems, or for the care of children, elders, and/or other dependants. Therefore, working in conjunction with other systems and domestic violence advocates, health care professionals are in a unique position to respond to domestic violence.

Eleven pre-conference courses will be offered on October 21. One will focus specifically on domestic violence within AI/AN communities and will address how health care providers and institutions can improve their response to domestic violence by adopting "best practice" clinical guidelines. Drawing from a national IHS/ACF Domestic Violence initiative with nine I/T/U health care facilities, the multi-disciplinary team of faculty and experts will discuss their particular approaches to serving AI/AN communities using clinical guidelines and locally-developed educational materials.

Continuing medical education (CME) credits will be offered to physicians. The FVPF has been approved to offer continuing education credits for psychologists. The FVPF is pursuing continuing education credits for registered nurses and social workers. Registration opens May 15, 2004; go to *www.endabuse.org/health/conference*.

Also, the 13th conference of the Nursing Network on Violence Against Women International (NNVAWI) will be held immediately following the FVPF's conference, October 24-26, 2004 at the Boston Park Plaza Hotel. The NNVAWI was formed to encourage the development of clinical practice that focuses on the health issues relating to the effects of violence in women's lives. For registration and more information, see *www.nnvawi.org*.

Change of Address or Request for New Subscription Form

Name _____ **Job Title** _____

Address _____

City/State/Zip _____

Worksite: ☐ IHS ☐ Tribal ☐ Urban Indian ☐ Other

Service Unit (if applicable) _____ **Social Security Number** _____

Check one: ☐ New Subscription ☐ Change of address

If change of address, please include old address, below, or attach address label.

Old Address _____

THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(www.csc.ihs.gov).*

Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at *www.csc.ihs.gov.*

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

PRESORTED STANDARD
POSTAGE AND FEES PAID
U.S. DEPT. OF HEALTH & HUMAN SERVICE
PERMIT NO. 5691

CHANGE SERVICE REQUESTED

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300