

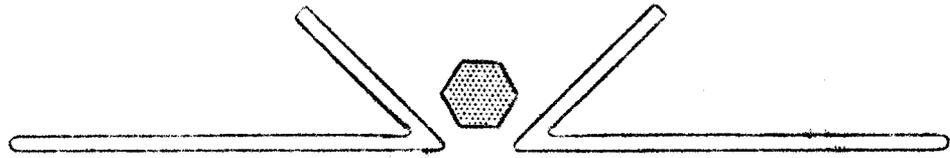
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INTER-AGENCY HEALTH MEETING (NAVAJO)



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JOINT STAFF MEETING
WINDOW ROCK AREA OFFICE, DIH, PHS - ARIZONA STATE DEPT. OF HEALTH

PLACE: Phoenix, Arizona

DATE: January 9, 1969

CO-CHAIRMEN: Dr. George Bock, Director
Window Rock Area Office
U. S. Public Health Service

Dr. Mel Goodwin, Assistant Commissioner
Epidemiology and Program Design
Arizona State Health Department

U. S. PUBLIC HEALTH SERVICE - WINDOW ROCK AREA OFFICE:

Doctor George Bock, Director
Doctor Robert Vanderwagen, Deputy Director
Richard J. Anderson, Chief, Office of Environmental Health
Robert L. Bergman, M. D., Chief of Mental Health Branch
James M. Cox, Chief, Environmental Health Services Branch

ARIZONA STATE DEPARTMENT OF HEALTH:

Doctor George Spendlove, Commissioner
Dr. Mel Goodwin, Jr., Ph.D., Assistant Commissioner
E. C. Garthe, Director, Environmental Health Department
Dr. Frederick W. Baum, Chief, Maternal - Child Health
Chester Carpenter, Director, Div. of Planning & Technical Support
Miss Marian Carlson, Secretary
Miss Mary E. Copeland, Director, Public Health Nursing
Ted Taylor (T.K.), Chief, Mental Retardation
Lawrence P. Burinsky, Chief, Venereal Disease Control Section
Dr. George B. Rowland, Acting Tuberculosis Control Officer
Dr. Robert Smith, Assistant Commissioner for Health Programs
Miss Beth Ussher, Physical Therapist Consultant

ARIZONA COMMISSION OF INDIAN AFFAIRS:

Charles Gritzner, Executive Secretary

OPENING REMARKS BY DR. BOCK: My own feeling is that this kind of a session should have occurred a long time ago, where we, together, could talk about planning and regional medical program operations and these kind of things.

We certainly would like you to know what we are doing and we would like to know all the things you are doing.

(continued) are doing now more frequently in order that there is an exchange of information between the Division of Indian Health (U. S. P. H. S.) and representatives of the State Health Departments operating on the reservation.

Obviously the main idea of this meeting is to ask and answer questions. This is the primary focal point. As far as the Health Department is concerned, this is your meeting.

DOCTOR BOCK: Mr. Garthe, why don't you open this up and then we will respond or go into depth in any way you want to do it to get a fix on our 86-121 and our sanitation programs.

MR. GARTHE: In regard to the first remark about not knowing you better, it's just a matter of geography. We know the Phoenix (P. H. S.) group extremely well because they are close by. Geographically, we are at a great disadvantage in respect to your office and you, in respect to us (I have never met anybody here except Mr. Cox) so we will have to work harder and spend more travel money to make up for it.

As to the items to be reviewed in regard to environmental health, I suggested three. The Sanitation Facilities Construction Program was listed first hoping Mr. Anderson would explain it in detail because I don't think the people have much knowledge as to what a tremendous program it really is; what it is doing with its funds to make it successful.

I think those activities of providing water and sewage facilities in some cases are supplying a lot more than sanitation and disease control. They have a lot to do with mental attitudes and well-being. I think it is very important and would like to see it reported more.

The second point we had relates to a problem of Food Service Control possibilities on patent lands in the reservation as brought to our attention by your office. This could be more readily solved by us rather than by your office. I think the difficulty there is trying to make some of these food service operators toe the mark.

(continued) We just put a lock on them because, just as has been said, you can go so far with health education to a point when you have to make a decision whether the health of the community is going to suffer or we are going to close the establishment. The tribe adopted ordinances relating to trading posts and food and drink establishments about 1962. Now there are provisions within the tribal code for adoption of any subsequent P. H. S. code. For example: the 1962 regulations regarding eating and drinking are currently in effect. This is the code we utilize.

MR. GARTHE: You may be aware of the fact that we are trying to change our State regulations to be identical with the P. H. S. but have been quite unsuccessful so far.

DOCTOR BOCK: As you mentioned, we do have problems of food establishments on privately owned land within the area of the reservation. When one of these individuals gets very haphazard in his operations, we have no authority. Yet everyone realizes all of the people of the vicinity and mostly the Indian people on tribal land get the bad effect from his establishment. This is a point we should cover to find how, together, we could make this a more effective kind of operation so these eating and drinking places do come up to standards and are inspected intermittently.

MR. GARTHE: The answer, I think, is theoretically simple. The local health departments have had their state funds doubled but they have not in those two areas, as far as we know, seen to do more or better work or have bigger staffs.

MR. COX: This lack of services, I think, is being felt on the Navajo reservation by operators of some of these establishments and particularly the public schools. Within the past months, we have received letters from the Window Rock and Chinle Public School districts requesting environmental services be provided by us.

I think we sent you a copy of the letter we directed to the Chinle School stating we would do this on a time available basis and purely as a service to the school with an understanding that copies of anything we did there would be sent to

(Continued)

P. L. 86-121 is separate legislation enabling the P. H. S. to assist the Indian people in providing water, sewage, and refuse facilities. On the Navajo reservation, P. L. 86-121 was started in 1961. In general, the Public Health Service furnishes the materials and supervises construction while the tribe, when capable, provides the construction. On the Navajo, we are quite fortunate because the tribe has its own construction crews (6) working just on water and sewage facilities. These crews range from ten to twenty people on a crew and are capable of picking up more people as they need them on a particular project. They have their own ground water development organization with a geologist and well rigs. We utilize these well rigs a great deal. They have their own utility authority that is as modern as any with a computer and the whole works. Most of the water systems constructed in the larger communities are metered. We are working toward the day when people in smaller communities will be paying a flat rate of some sort. It is a little inequitable right now but we are trying to assist the tribe in some reorganization.

DOCTOR BOCK: This is a very important point. It is fine for us to be putting these systems in but if they are not properly maintained, there is a possibility in the next ten years of having to go back and do the whole thing over again. In view of this, the Navajo Tribal Utilities is the group we turn our systems over to on completion; the tribe maintains them. In off-reservation communities, water is not regarded as a paying utility and others usually carry the costs of water. Presently this is somewhat a problem on the Navajo. Some of these new systems are needed and are paying for themselves but there are systems that are not paying for themselves and ultimately, if this is allowed to continue, NTUA might have to drop maintenance and the whole business will go to pot. So we are now trying to help the tribe get a water utility authority just for water on the reservation and have a general ruling that all deliveries of water have to be paid for so the system can be maintained.

(Continued)

Since the program started, the P. H. S. has appropriated \$8,500,000 and the tribe has matched this with \$7,600,000. This is not all the tribe has done with water and sewage on Navajo. They have had several projects of their own, generally to provide water for their cattle and livestock where they have run water up to 10 and 12 miles. They have developed a number of wells that we are now trying to make suitable for domestic use also.

This does not include developments by the homeowner.

DOCTOR SPENDLOVE: What is the population figure on the reservation at this time?

DOCTOR BOCK: Estimates run from 100,000 to 118,000 including Utah, New Mexico and Arizona. There will be a new census taken next year. According to our birth and death rates, the increase on the reservation is about 3 1/2 percent a year. At one time our population growth rate was greater than some of the so-called population explosion countries of the world.

Some impact of family planning brought our rise to a plateau but it has started to go up again. The reason for this is the apparent increase year to year in the number of women of child-bearing age.

DOCTOR SPENDLOVE: What efforts are being made to educate the people relative to family planning, health education, sanitation, etc.?

MR. COX: We take a multidisciplinary crew into the homes. Due to our lack of resources, we don't do as well as we wish we could. My men speak in some of the chapter meetings and certainly we do have Public Health nurses in the field. We conduct a survey of understanding to determine their health knowledge and then attempt a program to upgrade the health status of the beneficiary. There is much to be desired. After a training program, we go back and where there is a faucet, they are using a dipper and a pail, where there is running water.

The new community health representative will have a tremendous impact on this. They will take educational material to the populace. We hope to have one in each chapter ultimately. They will help the people to have a greater understanding of

(Continued) In some instances, there was poor sanitation. Some schoolrooms were unvented with high carbon monoxide and other situations were found where there was no refrigeration to protect foods. Most of these deficiencies were corrected. Head Start helped P. H. S. to immunize better and to give an annual examination. 100 percent of the children in the four- to five-year bracket are eligible for the Headstart Program.

MR. COX: In this connection, we have also conducted a great deal of training of Head Start personnel in environmental health as well as nutrition; also, some training was done in first aid.

The tribe has ordinances for food handling.

We work in an advisory capacity to the tribe inasmuch as we conduct semi-annual inspections on all of their commercial establishments (approximately 210) writing a complete narrative report on our inspection that is forwarded to the tribal enterprises and trading department, to the Navajo Legal Department and to the B. I. A. Real Property Management Office for subsequent enforcement. There are regulations governing trailer parks, trading posts, barber and beauty shops and slaughter houses.

It is hoped the Navajo regulations will be changed to allow State meat to come onto the reservation.

Local "shade tree" butchering by the trading posts has been stopped the past three months by a joint memorandum from Dr. Bock, the Area Director of B. I. A., and the Navajo Tribal Chairman. Plans are underway at the present time to put up two small U. S. D. A. slaughter houses on-reservation.

A farmer can still kill for his own use.

Our institutional program covers the B. I. A. and O. N. E. O. Head Start schools, tribal jails and our own facilities. We have an institutional sanitarian in Window Rock serving as a staff sanitarian for all of the service units.

We make 2 types of surveys on our institutions. One, our comprehensive survey includes water supplies, waste disposal, heating, and lighting, ventilation and the total environment of the school.

(continued) better coordination of all this would be desirable from their standpoint and that some clarification of what seems to be shifting of referral criteria from one year to the next--20-40 this year, 23-30 next year and 20-70 some other year, --and the implication that funds which were available to buy glasses for children who might ultimately require them has something to do with the referral criteria.

DOCTOR BOCK: In previous years, the Navajo Tribal Council allocated money for the provision of glasses for Navajo school children. The tribe in the past allocated anywhere from \$120,000 a year and in recent years, due to budget problems, down to \$80,000 a year. They then went out and contracted with private optometrists to come up and refract those children who had been screened and found to have certain vision deficiencies and then provided glasses. The changes in the 20-40, 20-50, 20-70 eligibility always depended on with whom they contracted and how much it was going to cost, calculated on about what percentage of those children they would take care of. In the last two years prior to this year, with \$80,000 in their budget, they were only able to refract and provide glasses to those with only a vision of 20-70 or worse. This year I was able to have the Division of Indian Health take over the eye-glass program. We now have our own optometrists. We have three commissioned officer optometrists going out and doing the refractions and we are buying the glasses at a very reduced rate for an average of \$6 to \$7.50 a child where previously the tribe was paying anywhere from \$20 to \$30. Approximately 6,000 pairs of glasses will be supplied this year.

DOCTOR VANDERWAGEN: 22,000 children have been screened. The screening procedure is initialed by the teachers and they are the ones who are trained by the American Society for the Prevention of Blindness. If 20/40 or worse, they are referred to the school nurse and screened more carefully. The pre-schoolers really have no services covering them including Head Start and kindergarten, screening -yes, but no funds for glasses. We have applied for this in our budget request for next year. We are getting close to 90 % coverage of all our school children.

(Continued)

One of the major problems is getting the mother in early for pre-natal care. In the past 5 years, there has been an improvement. This is a good side result of family planning. Post-natal care has also increased. At Tuba City for example, there was an increase in post-natal care of 60 percent in one year after family planning.

The functions of the Community Health Representatives well reflect directly almost priority-wise with the health problems of the community so we will be talking about the major health problems and this includes maternal and child health. DOCTOR VANDERWAGEN: We have 2 new programs that help to get prematures in; one is O. N. E. O. that has received a grant of \$100,000. Dr. Bock was able to persuade them to put aside a goodly portion of the amount for this program. Beginning this month, any premature infant will be helped until the money is gone, about 130 infants all together.

The other is a supplemental food program which the U. S. D. A. has initiated on Navajo. It provides extra milk, syrup, etc., in order to get the supplemental foods, a prescription must be obtained from a nurse or physician enabling the small child to have an examination.

* * * * *

DOCTOR BOCK: Dr. Goodwin brought up a very good and important point during the break regarding our mutual problems in the environmental health aspects of the program. So far we have not come up with any beginning decisions of policy on how we are going to get together and handle these.

Let us first discuss the problem of having people adhere to sanitation principles with regard to food establishments on-reservation but on non-Indian land. In this respect, we are hog-tied. Jim, would you like to speak to this?

MR. COX: Certainly these are out of our jurisdictional area. I don't have any answers.

DOCTOR BOCK: Is it possible that the county will have this as their responsibility? We could meet with them and arrive at some improvement in the kind of surveillance

(continued) cooperate better in the general health department setting and I am going up to talk about how this might relate to tuberculosis.

MR. COX: Could this be a joint meeting?

DOCTOR ROWLAND: Maybe this approach could be developed, however, I don't want to kill this meeting with too many controversial points. This is Dr. Thomas' first very gentle effort at indicating he is willing to take an active part in some cooperative gestures.

DOCTOR SPENDLOVE: I think it best that we stay out of that because the State Health Department went up there and tried such a proposal without success. If it was brought up by a fellow county, it might be acceptable to them. It could be brought out in a preliminary type way without pushing it.

DOCTOR BOCK: At the same time, we could be talking about the other problems that came up such as the school program.

MR. COX: Again, I think we would be receptive to any suggestions. Are the ways we handled the Chinle and Window Rock situations satisfactory with you?

MR. GARTHE: I think there is a little difference on the schools in relation to food because the laws of the state are quite clear that the local health department has the responsibility for food under normal conditions. The responsibility on schools seems to be relatively unclear. There are old statutes and regulations that had a lot on schools in Arizona. The present status with reference to intent and meaning is unclear.

In 1953 the famous Marana case threw out this stuff; the remaining remnants are unclear. Now somebody else might be able to clear this up quickly if he had a different viewpoint on schools. Part of this is because schools involve different functions. For example, we figure as far as public water supply for schools, this is primarily the state's responsibility; food is not.

MR. COX: Dr. Vanderwagen's reply to the Superintendent of Schools at Chinle set up the procedure for handling all reports on an un-official basis. Does this meet with your approval?

MR. COX: It will be no problem at all. We would continue to provide services, if requested to do so by the superintendent. We will also make copies of all correspondence.

DOCTOR BOCK: I would also think in holding your meetings, you would try to come up with some way of stimulating or at least making whoever else has the responsibility aware that there is a need here that is not being met. P. H. S. might not have the people to do it. We are in a position where we can offer some services, and will be happy to do what we can. In the same sense, we have other responsibilities that also must be met. I think that the meeting Dr. Spendlove is suggesting is an ideal way of getting this kind of thing out in the open where through discussion we can come to a conclusion as to who has what responsibility.

Are there any other questions you can think of now that might help you in making a decision?

DOCTOR GOODWIN: I think that covers it. I just felt a little uneasiness because we had mentioned the issues but never had really indicated how we were going to get together on working out the solutions. I think this is a good start.

MISS COPELAND: In regard to the proposed Chinle Nursing Home: If you will look on Page 4 of the appendix, Mr. White has summarized pretty well what has developed. The tribe plans to build this home. It will be owned and operated by the Navajo Tribal Council. The agreement was drafted and sent out and a suggestion was made and agreed upon; however, if everybody's in accord with the agreement, we need this in writing.

DOCTOR BOCK: Do you know where that is being held up?

MISS COPELAND: No.

DR. BOCK: As you know, I made an amendment to the agreement and it was my understanding that everyone agreed on this.

MR. COX: I will check this out when I get back.

MISS COPELAND: If you get in touch with the people up there who were involved at the original meeting and find the agreement, we could move ahead.

(continued)

Immunization was not an agenda item but it falls into this general concept. I don't want to get too far into this but our special project grants all run out this year for V. D. T. B. immunization was a specially funded item. Plans are now being developed and Dr. Rowland is taking the principal leadership in the project for comprehensive control of communicable diseases.

There will be an omnibus project developed that would envision maintaining register systems including assistance not only for T. B. and V. D. but other elements of communicable disease operations. We would put all of these data, the immunization records, the whole works into one depository so you can identify what is happening to individuals in specific areas on the whole problem of public health services as they relate in the control of communicable diseases. That is a long way to say yes, but in other discussions, you might want to know that this is the idea we are working towards and we will talk about it more in the afternoon.

DR. BOCK: At the present time, after the case has been treated and contacts have been traced and treated, is there no follow-up at all?

MR. BURINSKY: None whatsoever. Unless we encourage the men to do so when in the field. If when they are in the area and they see previously treated patients, they are encouraged to refer the patient for a follow-up serology or provide one for them on the spot; being certain this information gets into the records as a part of the follow-up process.

As we inadvertently interview the patient sometimes after the fact, as many as 2 to 4 weeks after the initial treatment was administered, we will give routine follow-up serology at that time.

As an additional service, this information is provided to the medical records section of the facility where the person first received treatment. This is usually not a normal routine.

DOCTOR BOCK: This is not a set established mechanism?

MR. BURINSKY: No, it's not universal yet. I think it needs to be that way.

(continued) As you know, we have had a seminar where all of the technicians were taught the technique and all will be doing it.

MR. BURINSKY: Another of my concerns is the recent findings of studies conducted by the American Social Health Association in respect to reporting by private physicians. It was suggested that in Arizona, one in nine cases are reported with primary or secondary syphilis; 1 in 6 reported of other kinds of syphilis; and 1 in 16 of all gonorrhea cases. Physicians at federal facilities were not included in this study; but I know on the basis of experience after talking to doctors on-reservation that gonorrhea is not reported. I would like to see some effort taken to insure a little more uniform complete reporting at least of the gonorrhea problem to make a determination of how wide spread the problem is. The main reason I am concerned about this is that a lot of these physicians will be going into the community in private practice and if we do not develop some good attitudes now and develop some good habits, we are going to have an even greater deficiency in the number of cases reported in the future because the last time this survey was conducted, in 1962, the spread of gonorrhea reported was 1 in 8 and it has already doubled. Now it is 1 in 16 that is not being reported so we are really concerned.

DOCTOR BOCK: I will check and see what we can do about that.

DR. VANDERWAGEN: One of the reasons for this is that there is not much you can offer a physician in this just because he reports it.

MR. BURINSKY: Right. However, I think if we can first determine the problem, we can make some changes or adjust the program to do that.

DR. VANDERWAGEN: To get young physicians to accept the concept that "I'm doing all the work of making these reports and 3 or 4 years from now, when I'm off on a residency in private practice, maybe something will be done." They say: "Why should I even bother to report it?" This is a matter of educating the people to public health which is not an immediate problem but has long-term implications.

MR. BURINSKY: This is the diagnosis: My experience says to always put it on a chart. It then could be easily reported in the medical record section along with your other communicable diseases.

DR. BOCK: We have nothing but praise for the V. D. program. The only criticism we have is that you don't have enough people. The magnitude of the problem is tremendous with what you know about it. Especially the syphilis portion of the problem. It is amazing that with the people you have you are able to accomplish what you do.

MR. BURINSKY: We will be getting more support from our office in the terms of the Highway 66. Due to the loss of one of our men, we are going to have to make some adjustment with support from Phoenix on the western end of the reservation and move the man we have there to the center of the problem in Gallup or Window Rock. I understand, too, that help will be coming from Albuquerque with the mobile squad New Mexico maintains. This should compensate for any change of personnel.

DOCTOR BOCK: When does the project end?

MR. BURINSKY: At the end of this fiscal year. This is the last year of the five-year period.

DR. BOCK: At the beginning of the meeting when I said we were having some problems, they were purely problems of personnel.

MR. BURINSKY: This has been one of the unfortunate things about our project up there since it started back in 1959. But for the most part, the people who are involved are generally very efficient and pretty productive.

DR. BOCK: We will see what we can accomplish as far as getting a follow-up system until a more sophisticated system comes in. I would think a tickle system like Dr. Rowland was talking about would work in most of our places except for a big system like when you get into Gallup. I am sure it would work in the smaller service units.

DR. GOODWIN: I didn't know that Dr. Rowland is so thoroughly involved in so many things, that the Indian Health Services' generosity and collaboration have absolutely no bounds. They contributed the Tuberculosis Control Office to the State Health Department. You can't get much more cooperation than that, can you?

(continued) I think you will agree with me that this is important to the control of tuberculosis involving the patient. They should do a lot more and I think they are quite willing to do so. At the present time our laboratory is operating somewhat over capacity and complaints will be coming to me until we can get this straightened out one way or another.

We are going to continue to have problems in stimulating all the collection of sputum, the specimens that needs to be done on the Navajo. The Phoenix area has been in the door longer than the Navajo and I think as far as the laboratory is concerned, they consider the Navajo an extra added load and they are going to be the ones to be scrounged, I think, in terms of the most recent coverage of T. B. bacteriology.

The plans I am now working on, which is still in the preliminary discussion state, is to have Dr. Swazey make available to the laboratory some space at the sanatorium. We can provide some additional support in terms of a person or two. I have talked with various people about some material needs to convert this laboratory to capacity work where it can take about 600 cultures a month which I think would be ample to take care of the problem.

The funding of the state laboratory in the past has not allowed a breakdown of categorical items. They can't say how much they are contributing in dollars or people to the tuberculosis program and their budget is equally vague when they apply for funds from the state as to exactly what kinds of programs are receiving the funds. They have a variety of programs besides T.B.; therefore, it is a problem of identifying how much they are going to contribute and how they can best increase the funding that is going to be necessary. I leave it there because we haven't gone much further ourselves. I think it depends somewhat on what you at Navajo do as far as your wishes for bacteriology. I feel that the State laboratory does exceptionally good work and probably better than any of the adjacent states. There are real advantages for using the superb people we have down here to assist in your bacteriology. On the other hand, you will have considerable volume once you get cranked up.

(continued) is no reason why there can't be an amendment to that proposal when and if it is funded. I have heard from Washington that it's been approved but not funded which, to me, doesn't mean anything until I get the money out. I would think that we could make an amendment to that proposal as far as getting some funds made available to either hire people who would be in a sense be assigned to the State Health Department, or actually be transferring funds over from the project fund to take care of this need. In the meantime, I will see what we are able to do. As you know, we are under a freeze, too, that just let up somewhat two days ago allowing us to hire 1 for 1 in certain positions directly related to patient care.

DR. ROWLAND: At this point in time we still have some work to do as far as facilities and getting things cranked up to the point where we can really take the volume that I would like to see coming out of the Navajo. I think there is some point along the line where we are going to have to sit down and talk about the longer term support of this kind of project, if you would like us to do it and we'd love to do it if you ask.

DR. BOCK: Yes, plus the fact that a plan is being conceived for having central laboratory facilities in Gallup. This is not just for T.B. or for specific kinds of programs but for chemistries and others. If we go into an automated system using some of the new machines, we feel it would pay us to have a central lab at Gallup with a retrieval system back to the source of the material but again, we are talking about 2, 3 or 4 years from now rather than something that is going to take place right away.

By the same token, we've been talking about V.D. and others. We are going to present something at a meeting next week to the Division Chief, Dr. Rabeau, as far as thinking about this for future funding. We will keep you posted; but right now I would say that this is a few years hence. We might be able to catch up with what problems we are anticipating if you still stay at the level you are, as far as your ability to process.

(continued) where it is not always very easy to live in some of the border towns. Theoretically, this is a function we could do effectively and perhaps allow you to redistribute your resources, such as training home health aids in T. B. control, paying the salary of a public health nurse. You could perhaps supply her with a government vehicle for travel. This travel is also a big part of our expense where it wouldn't be quite so bad for you. Just in terms of pure cost, certain administrative details of this will have to be worked out. This kind of direction, I think is the one we are thinking about. Again, this will become clear in the next month or so.

DR. BOCK: Is there any conflict at all as far as you can tell in the Navajo project as written with what you have in mind - is there any overlapping?

DR. ROWLAND: If you hadn't written a project at all, I probably would have been inclined to include much of what is in your project in ours. Since your project has been written and approved, I have to be careful and if it is not funded, I think you won't come out as well as if you hadn't written it at all. If it is funded, you will come out better. I have to be careful not to overlap it. This is why the language will be somewhat circumspect. If it overlaps they probably won't approve it. Dr. Goodwin, would you agree with that?

DR. GOODWIN: That is very definitely right. On the other hand, if it is a conference project for communicable disease, you don't have to specify geographical areas specifically and, in several respects, inclusion of the Indian populations does enhance the possibility of this project being approved in view of the Surgeon General's priorities. Minority groups plus services not available and several other factors enter into his consideration. I don't think there is any disadvantage of having that project there although, as Robin said, we must be careful in the wording of this project. Then we will have a reading on what the budget is like and what the approval looks like and probably can do a better job although there's not going to be that much time. This project has to go in by February 1 which means if both projects are approved, there will have to be some negotiation there which, of course, can be done.

(continued) and if we are funded, we will have a fairly good corps of people who are familiar with information and data collection systems. Ideally, we would be able to, through the birth certificates, do like what we are doing now; keep track of all of the births and update the immunization status periodically; also be involved in mass campaigns for short term support such as for measles. So we are going to place a big emphasis on this. In venereal disease, the follow-up procedure should be part of it which should require some sort of an input system used by everybody. If we try to saddle several service systems; one to your computer, one to our computer, one to somebody else's study, they are going to say 'forget it, it's too much work.' So, again, I think we are going to have to work closely together in our input system. In the first few years of the project, I think we are going to have a fair amount of direct assistance, home health aids and this kind of thing.

No matter what the project does, I think the State will hopefully be in a position to offer certain other concrete assistance. Certainly our portable mobile x-ray bus, if it has a role at all, takes 4x4 x-rays and according to the people who deal with these, (and I am more and more inclined to agree) these are diagnostic x-rays that can be read comfortably and be fairly happy with the results. Pima County is now using 4x4's to follow their cases. They have almost discontinued the 14x17 entirely. We also have a portable unit that requires a 110 volt outlet which is a box weighing about 4 pounds and takes a 14x17 x-ray of a fairly good quality although the radiation is a bit high. It can run off either a generator or a wall plug. This again would be direct assistance to you. We are certainly all available for any training you want to design for next year when the new medical officers come aboard. If you want to set up a 2- or 3-day session on communicable disease in general, we could develop a cooperative venture with our people to put on a training session for you. This is our function regardless of what the project supplies. We have also, in the past, supplied some direct equipment especially this year where you weren't able to supply your own. At the present time, all we can do as far as direct support is Betty Healy and staff at Flagstaff. They do get out to Winslow,

(continued) Now if, on the other hand, the state plan did not put this emphasis on communicable diseases and turned itself to some of the more esoteric things like building nursing homes, communicable diseases might not come out so well so it is going to take a pretty strong expression from the operational health programs as to what they want in the state-ranking priorities. Here again, you have to have ranking, not only on the basis of problems but also on the basis of specific concerns of groups of which minority groups will certainly merit special consideration. Being a born optimist, I tend to consider it a very likely possibility that the T. B. and other communicable programs will certainly not suffer in the shuffle.

DOCTOR BOCK: You have heard me talk to this point before, but my feeling is that when we can get the kind of dialogue going where we can identify the total need; and then what the available resources are now for meeting this need; then develop what the deficiencies are; and then come up with a plan which supplements whatever else the input is at that point in time; and then get down to the kind of planning-comprehensive health planning to meet the need without duplicating effort or leaving gaps that are not identified and that need filling, and then identify whose going to fill them, rather than 3 or 4 jumping in to fill them, we will accomplish good planning. I think this day is coming.

We feel somewhat ahead of some of the other areas in that just recently we have developed a new approach to developing our own program with this in mind. When you do identify a need with good dialogue with the State involved, we can then come up with what we can do together to meet the need.

I agree with you. I think the priority as far as the Navajo and other Indian groups plus other minorities are going to be looked on quite favorably.

DR. GOODWIN: As far as communicable diseases are concerned, those we can do anything about, of course, the minority groups have a majority of the problem. With 6% of the population of Arizona Indians, you account for 36% of new cases of T. B. and the same way with V. D.

DR. ROWLAND: The case rate of T. B. in the Phoenix area office last year was 240

(continued) services plus Navajo speaking people involved in the care and the whole gamit. A fairly imaginative type program perhaps combined with a half-way house on the reservation so that we are again dealing with a short hospitalization period, a half-way house where their families might be able to live with them and H. I. T. type housing with a controlled environment where they can get intensive supervision, and then move back up to the regular set up. I think this process, if we can get it running smoothly, will make so much more sense to the patient than the present two-year hospitalization at the sanatorium.

I don't know what it is at Albuquerque. At Oshrin, the patient stays somewhere around 440 days - well over a year. I think the process will make so much more sense to the patient as to our chances of gaining and maintaining his cooperation when a rather lengthy treatment was required. At the State sanatorium, the time has been shortened to 120 days.

DR. BOCK: One of the problems we have with this is what the Navajo people bring up themselves frequently. First, part of the problem is that they do not like to leave the reservation for long periods of time to be great distances from their families which we certainly agree with. At the present time, I think the general feeling is that you can treat tuberculosis in a general hospital that is properly sectioned off for intensive short-term treatment and then have a half-way house type of operation. So one of the alternatives we have right now is that in the new hospital facilities we build in Tuba City, Chinle and Ship Rock, we would have beds set aside that would take care of the acute cases of tuberculosis and then maybe use the old Tuba City hospital as a half-way house. Whether this becomes a reality or not, I can't say yes or no but this is some of the thinking we have been involved in. The Navajo people would like it better this way, as you know. If this doesn't become a reality, I think I would propose this as an excellent alternative. We have the same problem that we'll get into later about the mental health program. This is one of our big problems.

A mentally ill patient who leaves the reservation and ends up in a state

DR. ROWLAND: If the Albuquerque San starts doing a lot better work than it has done in the past, I would think it would be immaterial where you sent them - to Albuquerque or to Phoenix. I think at the present time, the quality of the work that is being done out here at the San is vastly superior medically at least to the work that is being done now at Albuquerque. I think with a little imagination we can make it a much better program as far as the individual patient goes. Again, we would have to have a block of beds. We couldn't just have one or two Navajos at a time. We couldn't justify spending the money that would be required to move the Navajo-speaking staff in to make the readjustment so the patients would feel at home.

DR. BOCK: Part of our acceptance of the intended move would be the guarantee that the quality of care would be equal or better than that they are getting at Mesa Vista and this has to be done by contractual arrangements with the medical school and others because this is one of the main objections I had in even thinking about the move - worrying about the quality of the care.

DR. ROWLAND: Not only the quality of the medical care but the on-going educational programs for the children; the rehabilitation.

DR. BOCK: At one time I guess we had as many as 40 there. I don't know what this means either. I don't know whether it is T. B. surveillance and that our impact as far as tuberculosis on the reservation is improved to the degree we are having less infants and young children infected or whether or not we are not cognizant of the entire problem but it appears that this is an improvement as a result of what impact the tuberculosis program has made.

When we are talking about this kind of program, I'm talking about the need for general medical and surgical beds as identified now in whatever new hospital we are contemplating. In addition to those, beds that would be specifically earmarked for tuberculosis and ultimately converted to something else, i. e. mental health or psychiatric beds when the T. B. need diminishes. This is where the big "if" is. We have been talking about a wing in the proposed hospital at Chinle as a physical therapy rehabilitation, reorientation for the quadraplegics

DR. BOCK: You have all of the nurses?

MISS COPELAND: Just the supervising staff representing public health, not school nursing. This is an area we will gradually branch into. You see, schools don't have supervising nurses in many places. We only have a very few places having a supervising nurse and we can't invite 300 school nurses so you get into this problem of not having somebody to represent the nurses.

Georgia MacDonough on our staff in the Maternal Child Health Section is a school nursing consultant. She is now working with school nursing problems and brings them to this group so that we get this coordination with school nursing problems which we haven't had previously.

DR. BOCK: The reason I asked the question is that we have a school nurse supervisor.

MISS COPELAND: The invitation that I would send to Miss Browning would be that she come and bring any supervisory staff member she would like. This is the way the invitation is issued to the Phoenix Office.

DR. BOCK: You probably know Jean McCullum, anyway, don't you?

MISS COPELAND: Yes, I sure do.

Being in the Winslow Office she would be a natural to attend the meetings. Our consultant nurse who works in the northern counties has already established a northern (five county) in-service education program for nurses which is held quarterly. It is possible that this could be expanded -- to include both school and Indian Health Service nurses. A joint committee would make all the plans and conduct the programs which would help the nursing services in the northern part of the state.

DR. BOCK: I fully give my support for inviting our supervisory nurses down for this meeting. We will make sure they will attend. In fact, I am confident they will be very anxious to attend.

MISS COPELAND: Our next program is now being planned and the announcements and invitations will be going out sometime next week. We are planning to send you a copy of it.

DR. BOCK: We have the group from Craig Rehabilitation come down four times a year now. They follow up cases that have been identified, either having been there or identified as being from other places. They have been holding conferences, keeping our people informed as to what is being done and also seeing patients who need follow-up appraisal. What we would like would be to set up in one of the newer facilities as relocation-rehabilitation type activity so these people would have some place to come back to where the families would learn what the care should be and where they could intermittently come back for re-evaluation. Not only would it be better for the patient but it would be a tremendous improvement in our cost. We might have a patient up at Craig for years, have him come back and within 2 months his skin is broken down and he has to be re-admitted for another 6 months purely because the follow-up at the home level was such that the patient was allowed to deteriorate. There is some activity in this area but certainly not enough. A couple of years ago we put in for a plan of physical therapy which never came to fruition purely because we didn't get funded, but hopefully, having a set-up at Gallup as a base, we could then have physical therapists go out to the various facilities and hold these kind of clinics and keep track of all the patients that have been identified as needing follow-up care and rehabilitation. Right now much is to be done.

I hear there is a new group opening up here in Phoenix. Doctor Young came down from Craig and he's involved. It's at Good Sam.

MISS USSHER: But they don't have any means for follow-up at Good Sam.

DR. BOCK: We've got some really unbelievable situations where a man is rehabilitated and then goes back to the hogan level and has been given a wheel chair and he is expected to wheel this around in the area.

Right now the Craig staff come down as a team. They bring their physicians, physical therapists, a social worker and some nurses; also an orthopedic surgeon and neurologist but not frequent enough because there is a three-month gap from each visit and a lot can happen in that period of time. I agree that this kind of

poses a number of problems. One is the fact that it was put up basically by the Vocational Rehabilitation people and this involves buying back the facilities or transferring responsibilities which is a pretty hairy situation right now, but Ron Peterson who is no longer with the University, now with the Comprehensive Mental Health Planning of Northern Arizona, is one of the ramrods. This might stimulate more activity in the area in the next year. If he switches the employers, maybe it will open more doors.

DR. BOCK: When they designed the hallways, you could drive a truck down them. I never could understand why they had to be that wide.

MISS COPELAND: I think we can move ahead in the area of staff development. Dr. Rowland, myself, and several others are going to get together. After that, Dr. Rowland is going up to meet with Dr. Thomas and others on the T. B. Program. As far as the counties are concerned, I think as we get reports of the activities that are going on, we can communicate with the area people to see if they have any questions and we can then find out if we have some specific needs in staff development among our staff and in the school nurse area. When we have this, we can plan a joint in-service education program. I don't want you to think that we will have a program just to have a program but it has to meet a specific need for the groups that are involved; sometimes we might participate with the staff in your area and all the staffs might participate. We might need your resource people and you might need some resource people from us. I think it will have to come and we'll have to define what our needs and objectives are and to try to set it up probably on a yearly basis; that is, what we are going to try to accomplish that year and then see if we do any of this, instead of just helter skelter. That's what we've been trying to do. Our program this year for the northern counties is in child growth and development. Our nurses in the northern areas are very lacking in public health per se. We have very few well trained, well qualified public health nurses so these nurses did not get growth and development. They got the sick child so what we are going to try to do now is improve this area so people can work better

program, I would like to make a plea that in your current and or future training programs, some presentation might be made on mental retardation and other areas of which I'm sure there are at least 1,000 and maybe 15 projects you would like to have them do, as you mentioned because we look at this as a way to continue the community worker concept by working through the existing agencies rather than having another set up of community workers going around the reservation talking about a specific category.

I am sure your objective is to carry a lot of areas and we offer our assistance in helping you develop training programs and/or bringing in people who might be able to do this as community health representatives.

In our recent meeting in Denver, one of our trainees, George Kellywood from Chinle, talked about the problem of a boy he had identified and was working with a family and granted that there is a lack of facilities on the reservation and in the whole Four Corners Area, as far as that goes, to work with the mentally retarded but the solution that some agency representatives suggested, and I'm not really aware of what agency, is that since this boy was identified as being mentally retarded, he should be shipped off to an institution. At the time, as I recall the situation, he was functioning fairly well as a baby sitter because his parents happened to be gone, probably from the effects of too much the night before. Dr. Dent raised the question: What can we do to help you and other agencies in the area; work with your people, the councils, parents and teachers, etc. in helping to adjust the environment to accommodate the youngsters who really shouldn't be shipped off to an institution; to make it possible for the youngster to stay in the area which is the objective of our total mental retardation program? We seem to see a number of youngsters down in the Valley of the Sun, perhaps because of lack of services in your area or perhaps due to a lack of understanding of how these youngsters might be worked with, they really have no need to be in an institution. I know it raises a problem of how to help people work better

We are writing a report. Would you be willing to help us review this documentation and recommendations and make them as strong as they should be?

DR. BERGMAN: This is not the only area but in many areas a large amount of money is spent in trying to find some way of getting a needy family on welfare. The fact that kids are starving doesn't qualify them.

DR. BOCK: Dr. Vanderwagen can speak to this. It happened to take place in Shiprock, New Mexico where a study was done to identify mentally retarded children in the school system. They were very well identified, plus Dr. Vanderwagen on the western side of the reservation did the same thing at Tuba City. Identification is one thing and getting the proper classrooms available plus other things needed to take care of the child is the big question.

DR. VANDERWAGEN: In the Tuba City-Kayenta service units (which is one B.I.A. Agency), there were 825 children who were referred by teachers as they were not doing what they should have been doing academically. Now all of these were not mentally retarded, some were academically retarded. Fifty per cent (50%) had normal mentality and could be developed under the proper circumstances. In our Shiprock project, we wound up with thirty-seven kids in school. At the end of one year, twenty three of them could go back to where they should have been. They were not mentally retarded at all. They had some other problem which was alleviated by individual intensive attention from a teacher in a small classroom.

DR. SPENDLOVE: That is something that should be in your report, Ted.

MR. TAYLOR: Another problem you reminded me of. We were up at Chinle in November. The school personnel in the public system were not aware of the fact that Title 6 of the Elementary and Secondary Education Act was available to them for special education programs for the mentally retarded. It was a little appalling to wonder how much this certain person was drawing in federal money for salary and not aware of what could be done. We wondered if it would be feasible to try in some way to help these people understand the kinds of resources federal and state that are available and how to go about it and get them.

legally. The concern of Drs. Lewis and Lofgren is to be involved in assisting you in whatever plans you have in mind if at all possible, and particularly if you look for the possibility of federal construction monies for mental health services.

In the state plan, one would have to be modified because it is all in one catchment area right now. If you go under your own catchment area the application for construction does come from the state and then goes to the regional level. This is the basic concern that the mental health people have. Our office would be involved at an early stage, if at all possible, unless you absolutely don't want us, rather than coming in at a later date; particularly if you have some federal people in. For instance, I would let Harold Dent come up to your country without taking me along. If you do want some federal people to come in, our people would like to come along. At the same time, it's cooperative planning and it is the same communication system as ours. That is the basic message I have.

DR. BERGMAN: At one time we were at a very tentative stage of planning. I think we are a little behind that point at the moment. What happened as far as that meeting with NIMH was concerned was that I talked to some of the people there about this possibility and they suggested that they come out and talk to us about it. It was their suggestion that we not involve the three states at this point because we did not know whether we wanted to involve one state or three or just how this thing could be done. This was an entirely a new problem to them with a catchment area in three states.

As things turned out, the meeting was somewhat discouraging. We got into this idea in the first place because the Chinle hospital which had originally been planned for much sooner, kept being put back and back and the possibility which had looked very good that there would be in-patient services and psychiatric services there seemed to dim a little bit so we began wondering if there was some quicker, easier way. The answer may be "no".

As rural mental health programs go, we are in fairly good shape. In comparison with the rest of that county area, I think we are fairly far ahead in the pro-

some other kind of financing. One of the things that made us think about the reservation as a separate catchment area was the language and other types of culture problems that mean that there are advantages to the facilities specializing in the care of the Navajos.

TED TAYLOR: There might be a better chance if you have a Navajo catchment area that you would get a higher percentage of federal money and if you were going to draw some money from all three states which is feasible. One of the things that I am happy about is that federal people are really excited when we talk about working in four states involving three federal regions. This hasn't been done and is quite attractive because we are running through some virgin territory. I think it would help in mental health but I can't speak for them now. Things can be worked out. It poses an interesting challenge, as the saying goes.

DR. VANGERWAGEN: I was interested in Dr. Bergman's remarks on the Navajo attitude toward the mentally retarded child. It has been several years since I have had any direct contact with the Navajo people but this is a feeling I had some years ago and I am delighted to see it has not changed. The Navajos do not want their children to go off to an institution. They are forced into it, usually because of economic needs, occasionally because of some over-zealous public health nurse or someone who sells them something, but they can provide, I think, better for the child even with the limited amount of food that is available, than they can in an institution because here he is in the family and is loved. He may not have all the food he needs but he does have the other things that he has to have which he does not get in the institution and the Navajos do not particularly look down on these children.

They are a problem and they know they are a problem but they still herd sheep, haul water, haul wood and do any number of things. They are useful and they feel useful. I agree wholeheartedly with Bob's diagnosis of the situation and approach to it.

TED TAYLOR: Dr. Bock, my only comment is that we certainly have appreciated the support and openness with which this project has been going since April and look forward to continued involvement project or no project for the people we serve.

DR. BOCK: We're all for that. Again, I think the highest priority as far as alternatives would be a method of treating the psychiatric case in our own facility acutely and then having some kind of a halfway house or a nursing home psychiatric-oriented to take care of them as an immediate step and then finally getting them back to their own families. This would be the high priority alternative. Again, this is dependent on the things we talked about as far as tuberculosis.

Hopefully, we will get this kind of response in our new facilities and this kind of service. Right now we are planning on having a partial service of this kind possibly in Gallup if we are able to get the kind of personnel we need to run it. As you know, if you have a psychiatric service in a general hospital, you need quite a staff over and above what you have in that hospital at the time to handle that kind of load plus security measures, etc.. Gallup has some security rooms, our other hospitals do not, so it would be very hazardous to try and institute in any of our other hospitals. Though we have been forced to do it on occasions.

MIGRANT LABOR QUESTION:

I know there are federal funds available for communities through the Migrant Labor Act to make application for the provision of health services to migrants of the community. They are pretty liberal types of matching funds and yet many, many communities do not take advantage of it.

There are some migrant camps in Arizona and there have been improvements in some of these. The tribe comes down to look at them all. We know in other states and Arizona there were conditions that were identified as deplorable for migrant workers. We again offer our assistance. We would be very happy to make our people available to go down and evaluate these camps the same as we're talking about those other sanitary evaluations with the hope that whatever was identified, would then be followed-through and corrections made.

as compliance with the existing laws. I am sure the existing migrant sanitation laws that you do have probably are at least equal to the Bracero Program.

DR. SPENDLOVE: Yes, I think even though our law may need some correction. The fact we don't have perfect law yet, I don't believe there is a reason why we should wait if there are conditions that need some work done, please let us know about it.

DR. GOODWIN: This is a problem that Dr. Smith is inheriting and he hasn't had a chance to find out how bad it really is.

It is all under federal funds. Counties, of course, apply for funds directly and their grants awards are made to the counties. There is only one that is real good and that is Maricopa County. There is another grant in Pima County and another in Yuma County. Now these provide all health services, preventive and direct medical care for migrant laborers. The state also has a project but it hasn't any geographic distribution or orientation. This funds a sanitarian and other staff that would be available if you wanted a specific survey made in any specific area. These people would be available to do that.

Now, having said that, among the things that we need to do is to see that this program is related to other activities adequately so that you can take advantage of other resources that are available in other operational programs. Because the migrant health section has operated independently without too much contact with the rest of the programs. I would say though, do the squeaking and this is the way to get it straightened out and make it available. George, I wonder if Mr. Gritzner has any comments to make?

MR. GRITZNER: Sometime ago a problem existed at the Navajo Labor Camp at Fredonia. While checking out the problems that existed on the Kaibab-Paiute reservation, the Arizona Commission of Indian Affairs came in contact with a situation in a housing area of sixteen houses in Fredonia. Six of them had roofing missing. One was reported to have had sixteen people living in it. Drainage was terrible; the toilets were unclean; there was no provision for garbage; no electricity. It was absolutely the worst situation we knew of. What could we do about it? We contacted

great deal of pride for what they have been trying to do over the years. This seems to be one of the finest examples of their work.

DR. BOCK: Thank you too, Mr. Gritzner, for all the cooperation you always give us and the fact that by needling us, we got together.

MR. GRITZNER: It isn't easy to get important people together. We have been working at this for almost three years. Always there would be someone die or be transferred.

As I was taking notes, it was evident that there were several occasions when the desirability of having various meetings were mentioned. Hopefully, you will get together and have these meetings. This may take care of it. If you would like to continue these meetings, it would be up to Dr. Spendlove, Dr. Bock and the rest of your gentlemen. The Commission is very anxious to go on working, no matter how difficult it is to get a meeting. If you want one, we can arrange it.

DR. BOCK: I would like also to ultimately have Indian representation at these meetings. It is amazing how much you learn by listening to the Indian people. Especially we have learned by listening to the Indian people as to how a program should be conceived and presented and ultimately accepted.

I keep telling my staff we could actually develop, without the help of the Indian people, a program which theoretically should be ideal but if they don't accept it, it is not worth very much. Their acceptance frequently depends on the amount of involvement they had in the development of the program.

Now we have found that whenever we had something new or something which might cause concern in the slightest degree, by involving them early in the development of the plan, it becomes a useful thing. We found this to be very much so in the development of the family planning program. We had them involved a lot in the alcoholism program, the mental health, plague control and trachoma programs so they know what you are doing, why you are doing it. They tell you how they think is the best way to approach the people. It is amazing how many steps you save by involving them. I would like, in the future, to have some input, and some contact with

when we have Navajo members and anthropologists involved giving background of the cultural aspects of Navajoland along with a resume of our major health programs. A lot of new people come out for it.

DR. SPENDLOVE: I've attended most meetings around here with Dr. McCammon.

DR. BOCK: You will have a standing invitation to our annual orientation meeting and other meetings we will be very happy to invite you to. Well, I guess that about puts the cork back in the bottle. Thank you again.

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APPENDIX A

Joint Staff Meeting -
Window Rock Area Office (PHS)
January 9, 1969
Information copy

2. Recommendations by ASTHO Subcommittee on Indian Health

STATE HEALTH OFFICER'S AND INDIAN HEALTH SERVICE -

REFINEMENT OF COOPERATION

The State and Territorial Subcommittee on Indian Health of the Health Services Administration Committee in contacting State Health Departments and Indian Health Service's Area Offices regarding the five areas of (1) Immunization, (2) Investigation of Disease Outbreaks, (3) Disease Control Surveys, (4) Laboratory Services, and (5) Statistical Services and Registers, has found that:

1. State Health Departments and Area Offices of Indian Health Service are generally pleased with cooperative relationships in the provision of health services to Indians and wish to extend them.
2. There is a need for more detailed joint planning of health programs on reservations and in adjacent areas.
3. Better systems are needed for exchange of information from State and local health Departments and from Indian Health Service.
4. A standardization of the Indian Health Service reporting with Public Health Service reporting requirements would be helpful.

RECOMMENDATION NO.1 - INFORMATION AND PROGRAM COORDINATION

In recognition of the cooperative atmosphere which exists and the value which could be derived from joint planning and coordinated operation, the ASTHO recommends that appropriate members be chosen from among Indian Health Service Area Officers and State Health Officers for an ad hoc committee to draw up a mutual statement of intent covering points 2 and 3 above, and report to the Subcommittee on Indian Health in 1969 in time for action by the Annual Conference.

RECOMMENDATION NO. 2 - IMPROVEMENT OF REPORTABLE DISEASE PRACTICES

In recognition of the desirability to avoid duplication of effort and to promote ease of reporting and analysis, it is recommended that the Indian Health Service adopt Public Health Service reporting requirements in all Area Offices; review its reportable disease practices for compatibility with applicable State requirements; and meet with each State to resolve any differences.

RECOMMENDATION NO. 7 - REPLACEMENT OF PERSONNEL SERVING THE INDIAN HEALTH PROGRAMS

It is recognized that great improvements in the health of American Indians and Alaskan Natives have been made since the PHS was given responsibility for this program in July 1955. Nevertheless, because of the 20 year initial lag suffered by these "First Americans", they still are among our most disadvantaged citizens from the standpoint of housing, education, and employment; as well as health. Therefore, the restrictions of Public Law 90-364 which prohibits filling more than 3 of 4 vacancies on a Department-wide basis, affects these disadvantaged people more than the average person served by the Department's overall programs. Therefore--

It is recommended that the Secretary of the Department of Health, Education, and Welfare increase the priority assigned to replacement of personnel lost from the Indian Health Service, above that of the general level of replacement of personnel in the Department of Health, Education, and Welfare as a whole.

RECOMMENDATION NO. 8 - TRANSPORTATION ON INDIAN RESERVATIONS

The availability of adequate and accessible transportation has long continued to be a problem on Indian Reservations. While school bus transportation has been developed and improved, little has occurred to meet other basic transportation needs, and particularly those that are necessary to assure the effective use of health facilities and staff. To economically and effectively meet this need, the coordinated concern and action of the Public Health Service, the Bureau of Indian Affairs, and the Tribal Councils will be needed.

It is recommended that the Secretary of Health, Education, and Welfare consult with the Secretary of Interior to take joint appropriate action to further study this problem and develop a suitable plan by which reservation transportation needs, essential to the effective functioning of numerous programs including education of the Bureau of Indian Affairs and the Public Health Service, Indian Health Services programs, are met and thus increasing the viability of Indian communities.

RECOMMENDATION NO. 9 - INDIAN HEALTH SERVICE TRAINING PROGRAM

The Subcommittee on Indian Health reviewed and was impressed by the accelerated training program relating to Community Health Representatives; to Indian Health Staff in Epidemiology and Health Program Planning; and to the proposed training in Health Program Management, Environmental Health; and in Public Health Concepts and Practices for Community Health Workers and other related categories.

It is recommended that the Indian Health Service Training programs be continued, expanded, and refined, with the recognition that such quality instruction and training is a major step towards solution of the manpower shortage in the field of health.

3. Licensing Proposed Chinle Nursing Home (cont.)

In November, Mr. Mallett advised of a change in Paragraph 6, page 3, of the draft agreement desired by Dr. Bock. This amendment was acceptable and interlined to conform. Nothing has been heard from the other recipients of the materials.

APPENDIX C

4. Tuberculosis Control

History: Tuberculosis is still a major problem on the Navajo. In 1967, there were 65* new active cases on the Arizona portion of the Navajo Reservation. The register as of June 30, 1968 showed 241 patients classified as active or probably active and an additional 113 classified as activity undetermined. A reactor rate of 3.9% and a conversion rate of 1.7% among six year olds confirms the presence of infectious tuberculosis.

In this area of inadequate resources, high mobility and endemic disease, cooperation is essential to eliminate tuberculosis as a public health problem.

Cooperation in the recent past has been excellent and includes:

1. Combining information in the use of the automated register of the Tuberculosis Control Section of the State Department of Health.
2. Encouraging the use of the excellent State Laboratory in areas where adequate mycobacteriologic facilities do not exist.
3. Providing liaison and consultative services where appropriate.
4. Providing equipment on loan in certain areas where equipment could not be purchased.

The future of the tuberculosis control on the Navajo Reservation depends upon several factors:

1. The adequacy of the DIH and tribal personnel. This relates primarily to the fate of the tuberculosis project funds applied for by the Navajo Tribe. If the project fails, the direct assistance of the State Health Department, Tuberculosis Control Section, voluntary organizations and other medical programs is going to be needed in a cooperative program with the Division of Indian Health.
2. The adequacy of consultative services. The resources of the State Health Department, Tuberculosis Control, are and should be available for training and consultation.

*This is the number reported to the state. Actual number is probably considerably higher.

5. Venereal Disease Control (cont.)

5. The Navajo people prefer to communicate in their native tongue when confronted with health workers.
6. The inability of the individual to accept the concept that he has syphilis unless he has another infection which causes him to seek medical care.

In our program to eradicate syphilis on the reservation it is necessary to deal with each of the problems mentioned previously. While there has existed in the past an inability to rapidly transmit epi information to the field staff due to lack of a suitable telephonic system on the reservation, the problem has been side-stepped by the installation of a console radio system in the headquarters office and each of the three vehicles assigned to VD control casefinding activities on the Arizona portion of the reservation. Now it is possible for the coordinator to communicate with field investigators on most of the reservation.

The language barrier is breached by the use of two full-time Navajo Indian venereal disease investigators.

The VD control staff on the reservation consists of the coordinator and two venereal disease investigators. It is their responsibility to conduct infectious syphilis epidemiology on the reservation. Supportive casefinding services are provided by the State's VD control staff in Phoenix.

In addition to epidemiology a reactor follow-up program is conducted on the reservation. Each person with a reactive syphilis serology is followed to a medical disposition.

Involvement of staff members in information and education activities is necessarily confined to those activities which are designed primarily to support casefinding efforts. Activities engaged in are limited to those which yield positive results in terms of infections brought to treatment, patient cooperation, medical and professional cooperation and increased public awareness of the VD problem.

Complete diagnostic and treatment services are available at medical facilities operated by the Division of Indian Health. Darkfield microscopy is performed at five health units (Chinle, Fort Defiance, Kayenta, Tuba City and Winslow) in the Arizona portion of the reservation. Each of these units have lab facilities to perform syphilis serologies with the exception of Kayenta.

On August 21, 1967, Doctor Bock proposed that syphilis serology tests should be performed on all in-patient and out-patient service unit admissions. However, information from our coordinator at Window Rock indicates that darkfield microscopy is not performed routinely on lesion suspects and all admissions are not receiving routine serologies. Implementation of the policy in toti would provide additional intelligence not now available enabling VD staff to more accurately ascertain and assess the syphilis problem among the Navajos and their non-Navajo Indian neighbors.

ATTACHMENT

| <u>PERIOD</u> | <u>ARIZONA</u> Number/Rate | <u>NAVAJO PROJECT</u> Number/Rate | <u>% of State Total</u> |
|----------------|-------------------------------|--------------------------------------|-------------------------|
| July-Nov. 1968 | 204/12.1 | 72/116.1 | 35.3% |
| Fiscal 1968 | 286/17.3 | 79/131.7 | 27.6% |
| Fiscal 1967 | 286/17.8 | 54/ 93.1 | 18.9% |
| Fiscal 1966 | 213/13.4 | 58/101.8 | 27.2% |

EARLY LATENT SYPHILIS

| <u>PERIOD</u> | <u>ARIZONA</u> Number/Rate | <u>NAVAJO PROJECT</u> Number/Rate | <u>% of State Total</u> |
|----------------|-------------------------------|--------------------------------------|-------------------------|
| July-Nov. 1968 | 154/9.1 | 31/50.0 | 20.3% |
| Fiscal 1968 | 147/8.9 | 49/81.7 | 33.3% |
| Fiscal 1967 | 131/8.1 | 32/55.2 | 24.4% |
| Fiscal 1966 | 111/7.0 | 40/70.2 | 36.0% |

TOTAL EARLY SYPHILIS

| <u>PERIOD</u> | <u>ARIZONA</u> Number/Rate | <u>NAVAJO PROJECT</u> Number/Rate | <u>% of State Total</u> |
|----------------|-------------------------------|--------------------------------------|-------------------------|
| July-Nov. 1968 | 358/21.2 | 103/166.1 | 28.9% |
| Fiscal 1968 | 433/26.2 | 128/213.3 | 29.6% |
| Fiscal 1967 | 417/25.9 | 86/148.3 | 20.6% |
| Fiscal 1966 | 324/20.4 | 98/171.9 | 30.2% |

7. Maternal and Child Health (cont.)

b. Nursing and social service follow-up on premature babies transported and hospitalized under the Arizona Premature Project.

Problems revolving around separation of premature infants from their home territory and from the family during several months of hospitalization in Phoenix have been particularly bothersome in the case of Indian children because of the great distance and isolation involved and the difficulties in re-establishing contact between families and their babies at the time of discharge from the Premature Center. The problem probably goes beyond those few babies hospitalized under our transport project since the Division of Indian Health also sometimes transports premature babies for hospitalization in the DIH hospitals. Considerable effort is currently being expended by the MCH Division and personnel from the hospital centers in Phoenix to find better answers to some of these problems.

c. Practice of Midwifery

In the Lukachukai area, some Navajo Indian mothers continue to rely for delivery services on nurses assigned to the Mission at Lukachukai. These nurses are not licensed as midwives, although at least one of them has received a year's training in the practice of midwifery at Santa Fe, New Mexico. A discussion on what medical supervision is available to these nurses from the DIH and suggestions for ways in which the State Health Department could provide assistance to these nurses might be worth discussion.

d. Study of Perinatal Mortality

The Arizona State Medical Association--Arizona State Department of Health joint study on perinatal mortality is now being completed. As part of this study, a separate reporting on perinatal deaths occurring in Indians has been prepared. There is good reason to believe from an analysis of the statistics that there is considerable under-reporting of perinatal mortalities from among the Indian population, although this is not agreed upon by some representatives of the PHS DIH, nor by some members of our Division of Vital Statistics. A presentation of our reasons for believing that there is marked under-reporting and an opportunity to hear the opinion of Dr. Bock and his staff on this subject would be of interest.

APPENDIX G

8. Staff Development

It would seem advantageous to have programs of mutual concern to nurses in the outlying counties and those working on the Indian reservation.