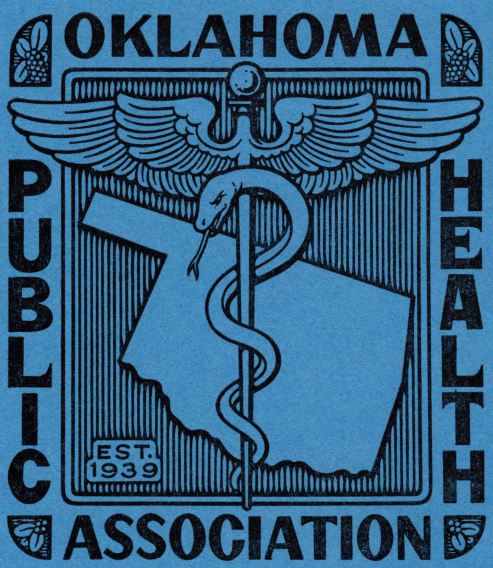
Oklahoma Journal of

PUBLIC HEALTH



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OKLAHOMA PUBLIC HEALTH ASSOCIATION

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OKLAHOMA JOURNAL OF PUBLIC HEALTH

Volume 4 JANUARY 1961 Number 3

The Official Publication

OKLAHOMA PUBLIC HEALTH ASSOCIATION

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The President's Page

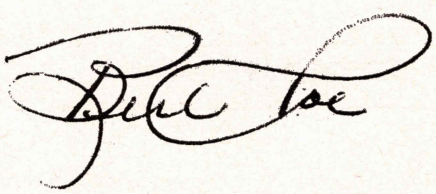
The time is near when we will again come together for the annual meeting of the Oklahoma Public Health Association. This will be our twentieth meeting, and will be held in Tulsa, on March 8, 9, and 10th, 1961.

We will have an opportunity to gain in professional knowledge by attending the various sessions where outstanding authorities in Public Health will discuss subjects that should be of interest to all.

We will receive also many intangible gains. These come through the renewal of old friendships, meeting new friends, and through discussion of common problems with understanding coworkers.

You will find an application for hotel reservations in this issue of the Journal.

I look forward with pleasure to greeting you in Tulsa.



Indian Health Area Led by Oklahoma

HERBERT A. HUDGINS, Medical Director (PHS)

Area Medical Officer in Charge, Division of Indian Health

We speak for each and every one of our employees in the U. S. Public Health Service when we thank the Oklahoma Journal of Public Health for the tribute of a special issue on Indian Health.

It is difficult when we review progress to believe that it was only six years ago that PHS was given complete responsibility for the health of the Indians and Alaska natives. We shall not use this brief space to reveal the need which PHS survey and study has uncovered, nor attempt to share with you the problems we yet face, even in Oklahoma, to bring the health status of the American Indian to that of the general population.

One of the Surgeon General's task-force committees referred to Oklahoma as a "potential showcase state" because here the Indian would naturally be expected to assume his own responsibility, under PHS guidance, for improving his health status, just as all citizens must accept this responsibility—county by county, and community by community.

In thinking about Division of Indian Health, I was amused recently while reading a new book[1] written by a nurse and a doctor. It was in a paragraph on The Public Health Team. "The pressures of work, the limits of time, and the enthusiasm of most public health workers, make it inevitable that 'jurisdictional' disputes will occasionally arise in which one professional group thinks another has usurped its functions or that individual differences of opinion may lead to conflict. A habit of accepting explosions or argument, a willingness on the part of the over-all administrator to listen to grievances

Photo Courtesy
Oklahoma Publishing Co.

1. Administration of Public Health Services: Ruth B. Freeman, R. N., Ed.D; and Edward M. Holmes, Jr., M.D., M.P.H. W. B. Saunders Co., Philadelphia, 1960.

and help the different individuals or groups to talk out the problems may be necessary until the team gets into high gear."

I have been amazed at the progress made in just such manner in the merging of former Bureau of Indian Affairs with old-time Public Health Service personnel. I continue to be amazed as we add to the team professional members possessed of competences which must be respected if others are to continue to progress. Examples of Area strengthening of health disciplines can be cited in three cases in just this fiscal year.

Our first Area Medical Record Librarian, Miss Margaret Bachnik, comes to us with experience in large and small hospitals here in America and in Hawaii. Such addition to staff reassures that medical records in Indian hospitals are to be maintained at standards deserving national hospital accreditation.

Also new is an Area Nutrition and Dietetics Officer to consult with dietitians at PHS Indian hospitals and professional personnel at PHS Indian field stations. This will provide a continuous nutrition service, combining field health and hospital programs. Miss Mildred Barry comes to Indian Health from the teaching staff of University of Rhode Island and knows this Area from service with the North Carolina State Board of Health.

Division of Indian Health is also fortunate to obtain the return to Oklahoma of Miss Ann Obert as this Indian Health Area's first consultant in health education. From Bogota, in Colombia, for six years she has worked with 22 states to develop health education services in local communities. Although she is already serving Oklahoma Indian hospitals and health stations in many ways, her time has necessarily been given mostly to the Choctaw of Mississppi and the Cherokee of North Carolina. As Indians in Oklahoma take advantage of new laws concerning PHS construction of sanitation facilities, the services of an Area Health Educator will be valued more and more by various tribal groups.

Elsewhere in this magazine the news in Sanitation is covered. We note here, however, Oklahoma's good fortune that at the most opportune time for Indians to take responsibility for improving environmental sanitation, our guidance will be from a veteran Public Health Engineer who is experienced in improving individual and community water supplies and sewage disposal. Edwin L. Dudley, formerly Area Sanitary Engineer for Phoenix Area, helped develop a special school for training Public Health Service Indian Sanitarian Aides. All four Indian Sanitarians in the Oklahoma Area have had advanced training at this school in Arizona.

Currently our Public Health Team for Indian Health in Oklahoma has benefit of Area personnel in medicine, dentistry, nursing, sanitation, pharmacy, social service, health education, nutrition, medical records, program analysis, and public relations. Just as important to Administration are the branches of Contract Care; General Services, including property management, procurement, and office services;

Financial Management; Personnel; and Construction and Maintenance. The service groups are sometimes the unsung heroes on a public health team. Without them, although a patient might have a surgeon, a nurse, and a dentist, nothing could be done for him because professional personnel would be helpless with no proper place in which to work, and no equipment with which to perform their necessary functions. Understanding one another's needs becomes basic to performance.

For this reason our public relations takes more the form of function-explaining as we report programs. Few items released by Division of Indian Health in the Oklahoma City area are designed to be used only as news. They are primarily written to inform our own people as to what we are doing, how we are doing it, and why we are doing it. These items are shared regularly with official leaders of Indian tribal groups, with related health agencies who voluntarily cooperate with Public Health Service in serving Indians, and the private physicians, local clinics, and community hospitals under contract to Public Health Service for medical services. It is hoped in this manner to build a public health team broader than Division of Indian Health. This will be necessary to eventually achieve the goal which Congress has set for Public Health Service in Indian health.

At present we have the help of eighty-two contract medical care services. These represent 3 State contracts, 17 hospitals, 8 clinics, 1 laboratory, 2 anesthetists, 31 physicians, and 20 dentists. In the article "Progress in Nursing Among Indians in Oklahoma," our Area Nurse Officer refers to relationship of federal and state health services for Indians in this state. In the article "Social Service in Indian Health's Medical Setting," our Area Medical Social Consultant has described our work with other related health and welfare agencies. She explains how community organizations can tie into the Indian Health program. There are forty organized Indian tribes in our five-state Area. Many of these are learning how to plan with Public Health Service that their people may enjoy health as abundant as other citizens.

As this goes to press, Oklahoma Cherokee, Kickapoo, Choctaw, Sac and Fox, Cheyenne, Arapaho, Ponca, Otoe, Shawnee, Seminole, Creek, Caddo and Chickasaw tribes are conferring with PHS personnel concerning better environmental sanitation. Some groups, particularly the Osage, have shown how planning for public health can pay off.

As we have inferred, Indian Health can be improved in Oklahoma by applying the Public Health Service team approach in the broadest possible manner. Freeman and Holmes put it in simple words: "The achievement of a team approach rests on a sound administrative philosophy and a flexible supportive organizational structure. In addition, it demands a willingness on the part of members of the staff to work with and through others, to teach and be taught, to lead and to follow, to share authority as well as to work with one another."[1]

Progress in Nursing Among Indians in Oklahoma

JEAN CLAIR CASEY, Senior Nurse Officer (PHS)

Area Nurse Officer, DIH

Since 1955, U. S. Public Health Service, through Division of Indian Health, has attempted to help Indians meet their health problems in a positive way. Today the Indians of Oklahoma enjoy all of the public health nursing services available to all citizens in the state, as well as some special Federal services yet needed by them.

In counties of particular Indian need the Public Health Service enters into contractual agreement with Oklahoma State Health Department to provide additional nurses for necessary folow-up and health education. These services are rendered through the State's own channels to help Indians take their rightful place in public health for all citizens. In addition to these contractual services rendered by the State, direct Federal nursing services are provided at seven field stations where the Indian population is very high or where no county health unit has yet been established to provide health services.

Through Oklahoma State Health Department, county nurses have made considerable contribution in the past two years in the special follow-up program of new born infants. Through a referral system worked out jointly by U. S. Public Health Department, Indian babies born in PHS Hospitals were visited by the county's nurse as soon after hospital discharge as possible in an effort to place the babies under health supervision at an earlier date. It is hoped that in reducing the many necessary admissions of Indian infants to hospitals during the first year of life that eventually the high infant mortality will be reduced.

A new baby in a home opens many avenues of approach to the health team serving the Indian family. Through mutual interest in the welfare of the infant, an entire family may come to understand the practical principles of maintaining health. In the first year that this program was inaugurated, infant mortality in Oklahoma dropped from 38.8 in 1956 to 30.6 in 1957. The importance of this is realized when one considers that "in 1957 12% of the Indian death rate occurred among Indians under one year of age as compared to 6% death among infants in the

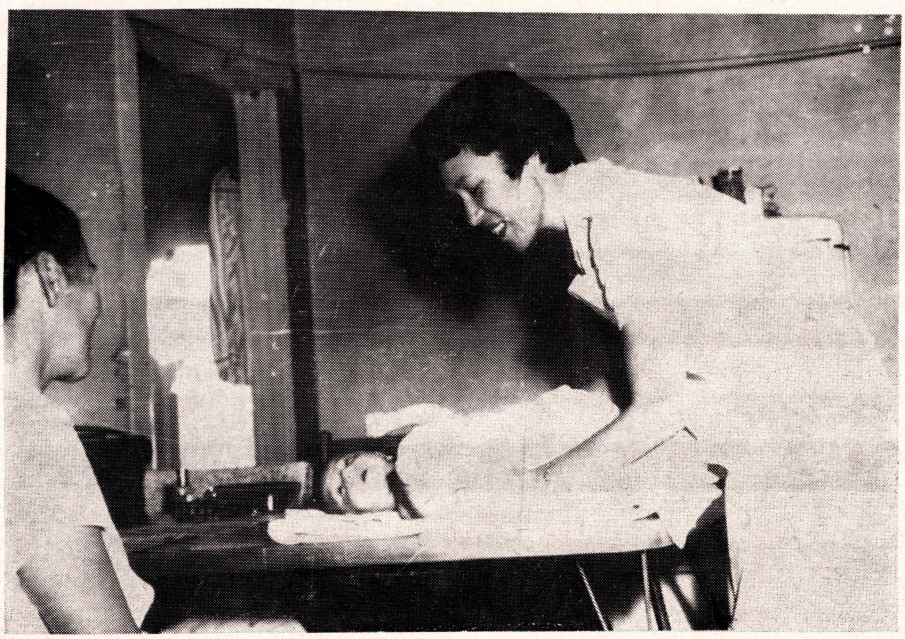
total population."[1] We refer to a health team, for nursing is not alone in getting this job done. Support to the nursing program is supplied by many other branches, sanitation and social services among them.

Joint planning is a continuous process in all public health programs. Perhaps nowhere is there a better example of such planning than by the representatives of the Oklahoma State Health Department, the Regional Office of U. S. Health Service, and Division of Indian Health's Area Office. Regularly we work together to evaluate services to Indians and to change program emphasis where indicated within monies and personnel available. With the combination of public health programs offered to Indians in Oklahoma today, we still recognize some areas of need within the state where we have been unable to extend our services.

PHS nursing services in Indian hospitals and Bureau of Indian Affairs boarding schools are an essential and inseparable part of our over-all program goal to provide a comprehensive type of patient care. Hospital, school and public health nurses, working together, and cooperating with other allied workers in the health field, have a unique and challenging opportunity to show the Indian how he may bring his health status to the level aspired to by all Oklahomans.

In the seven field health facilities now established, Division of Indian Health in the past five years

[1]Okla. State Health Department Vital Statistics



In a Cheyenne-Arapaho home, PHS Practical Nurse Pauline Pappan assists Watonga's Public Health Nurse by teaching a mother how to bathe a baby safely on a kitchen table. Mrs. Pappan is Choctaw, trained at the Public Health Service Albuquerque School of Practical Nursing.—*(Field photo courtesy of Watonga Republican)*.

has provided steadily more adequate housing, furnishings and the essential equipment with which to carry on a balanced program. Nursing personnel is being assigned to meet the need as surveys justify support. Staffing at these stations vary. At present in Oklahoma, Public Health Nurses are stationed as follows: Anadarko, Mrs. Opaline D. Wadkins; Antlers, Mrs. Phyllis Hullum; Carnegie, Mrs. Susie Burton; Hammon, Miss Mary V. Clark; Okemah, Miss Margaret Kilius; Pawhuska, Miss Elizabeth Corkill; and Watonga, Mrs. Frances H. Shaw.

Local physicians under contract with Division of Indian Health serve these stations, assisted by the Public Health Nurse. In instances where activities justify, staff is augmented by addition of a clinic nurse to assist the physician and so release the public health nurse for overall planning and operating the facility. A generalized public health nursing program is offered as well as clinical care.

At PHS Indian Health Station, Watonga, we introduced our first practical nurse to the field health program. Trained by Public Health Service at Albuquerque School of Practical Nursing, Mrs. Pauline Pappan, a Choctaw Indian, received special orientation and on-the-job training for her position over a one year period following graduation. Already, she has made a fine contribution to the Service, and is most enthusiastic about her work with the Cheyenne and Arapaho people in Oklahoma. A second practical nurse, Miss Ramona Randall, entered the Service at our Okemah station. She is of the Creek tribe and speaks their language, which is most helpful in interpreting services to older Indians. Under direct supervision of the Public Health Nurse, these practical nurses assist with clinic activities and make selected visits to patients in the home. Additional practical nurses may be added to the program after further analysis of the job yet to be done in Indian Health.

Indian Health nursing services are provided on a family centered basis to individuals and groups in their homes, in PHS hospitals, PHS clinics, community centers and churches. Public Health nurses also participate in special child health clinics, prenatal clinics and diabetic classes held in PHS Indian Hospitals, to improve the quality of patient care through assuring continuity of nursing service between hospital and home.

Since all public health nursing needs of the Indian cannot possibly be reached, emphasis is placed on the maternal and infant aspects of care. Each public health nurse must establish priorities for services based on an analysis of health needs and problems unique to her area. She must plan her services to coincide with those of other local health and allied workers. In Oklahoma, as more understanding each year is reached concerning federal, state and tribal responsibilities for Indian health, communities are coming more and more to the assistance of the Public Health Nurse in satisfying the desires of the Indian people to better their health status and so contribute to the welfare of the community.

PHS and Indians Join Forces Under Sanitation Facilities Construction Act

LAWRENCE J. PEREZ, Jr., Assistant Sanitary Engineer (PHS)
Field Sanitary Engineer, DIH
Oklahoma City Indian Health Area Office

Sanitation surveys conducted by the U. S. Public Health Service have pointed out the very apparent need of the Indian people of Oklahoma and in other parts of the United States for an improved environment in which to live and work. The Indian Sanitation Facilities Act, Public Law 86-121, signed by the President on July 31, 1959, gave the Division of Indian Health a new effective tool with which to actively cooperate with Indian tribal groups desiring to better their environmental sanitation.

The purpose of Public Law 86-121 is basically two-fold: first, to raise the health of the Indian people by providing for construction of safe water supplies and adequate waste disposal facilities; and secondly, to encourage and develop among them the desire and ability to use and maintain these sanitation facilities. An environmental sanitation education program, which has been in force since the inception of the Indian Health Program five years ago, is being continued and strengthened as part of the new congressional Act.

For the past three years, along with their environmental health education and technical assistance programs, the PHS Indian Sanitarians have been engaged in surveying the dwelling and environmental sanitation conditions in their respective areas. Results disclosed by these surveys are typified by those of Cherokee County, Oklahoma where 85 per cent of the rural Indian homes are obtaining water from unprotected sources; 45 per cent have no excreta disposal of any sort; 90 per cent have unsatisfactory excreta disposal facilities; and only 10 per cent dispose of their refuse in a proper manner.

Because the Indian population in Oklahoma is predominantly rural, mixed geographically with the rest of the population, most of the construction work will necessarily be done on a house-to-house basis and individual home systems will be in order. However, small multi-unit systems serving five or ten houses will be constructed where they are technically feasible and indicated economically.

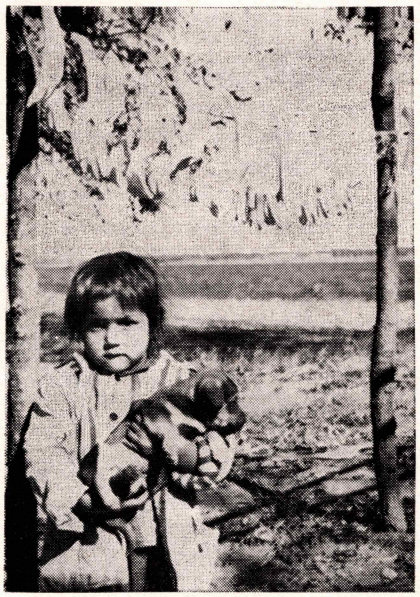
To accomplish the first purpose —construction of facilities—the Act authorizes the Public Health Service to request federal funds for the construction of basic or minimal water system and waste disposal facilities which should be present at all times. The basic water system consists of a water source (usually a drilled well with steel casing), a hand-force pump, metal water storage tank, inside water tap, and nec-

essary appurtenances for the entire system. Because of the poor level of waste disposal of the Indian population, the basic excreta disposal method will be by a sanitary pit with concrete slab and riser, and liquid kitchen wastes will be disposed of by a kitchen sink and liquid waste disposal trench.

All participants in the program are encouraged to obtain facilities over and above the minimal improvements listed. If an Indian family wishes to have an electric pressure water system instead of the hand pump system, they may make a contribution of materials or cash for an amount approximately equal to the difference in cost of the two systems. If a modern inside bathroom is provided by the Indian, the Public Health Service can provide funds for construction of the entire disposal facilities—usually a septic tank and tile field. All facilities will be designed and constructed to meet the Oklahoma State Department of Health and local sanitary codes wherever practicable and feasible.

To fulfill the second purpose—proper use and maintenance of the facilitiy—an Indian is required to make a minimal contribution of all rough and semi-skilled labor necessary to complete the project. In addition, the tribe is expected to make a contribution of cash, ma-

At Council House, near McLoud, Mr. John Nanaeto, Chairman of Executive Business Committee of the Kickapoo Tribe (left) sat by Edwin L. Dudley, Area Sanitary Engineer, when he explained new Indian Sanitation Facilities Act to Kickapoos. Standing, left, is Armin Saeger, Medical Social Worker, former missionary sent to the Kickapoo by Quakers; Paul White, Pharmacy Stock Clerk at PHS Indian Hospital, Shawnee, who serves as interpreter to the Kickapoo; Robert D. Grover, Bureau of Indian Affairs Field Representative; and Earl Grinnell, PHS Indian Sanitarian stationed at Wewoka.



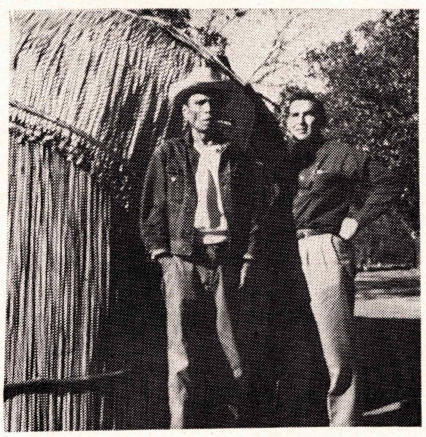
A Kickapoo child poses near slices of pumpkin hanging to dry in the sun. The pumpkin will be stored as winter food. Under new law, her family will obtain proper sanitation facilities.

terials, or skilled labor which is commensurate with the resources of the tribe and the number of tribal members benefiting. By making this a sharing endeavor between the Public Health Service and the Indian, it is hoped that the Indian will accept his responsibility for maintaining the facilities and making the utmost use of them. When a project is completed—considerable time will be spent with the family instructing them in making minor repairs, such as replacing washers, repairing pump rods, and fitting pump leathers.

A project is initially started when a tribe makes a formal request in a "Project Proposal" which indicates the tribe's desire to participate, long range plans for improving sanitation, and the approximate contribution that the tribe can make. Tribes are showing good cooperation and are generally realizing, with Public Health Service guidance, their responsibility for the health of their members. Tribes have set up revolving funds from which tribal members may borrow money for contributions for the more modern facilities and to make other home improvements along with the construction of sanitation facilities. Several tribes have set up a fund to pay the salary of either a laborer or a Sanitation Aid to assist the PHS Indian Sanitarian in construction. Where tribes have timber, sand, or gravel rights, they are furnishing these materials.

All indications are that Indian tribes in Oklahoma are willing to contribute a fair and reasonable amount of their resources to sanitation improvement. They thereby express their awareness of their role in Indian health. P.L. 86-121

(Continued on Page 27)



A Kickapoo visits with PHS Indian Sanitarian (right) before entrance to his father's cattail covered wickiup. The old gentleman prefers the type winter home of his ancestors, with smoke-hole in the roof, but will be glad to have a well for safer water supply. His son will supply the unskilled labor required.

Learning A Brighter Tomorrow

BERTHA M. TIBER, R.N.

Consultant in School Health

Division of Indian Health

The majority of Indian children in Oklahoma attend public school in their home communities along with their non-Indian neighbors. They participate in all activities and receive all of the same services as their associates. These services are supported by funds available through arrangements made by Bureau of Indian Affairs with the State Department of Education. The Division of Indian Health of the Public Health Service enters into this state school picture in only very limited ways:

1. Local Division of Indian Health units accept the referral of Indian students who meet eligibility requirements and need services not provided by the school or health department program. These may be medical care, glasses or other prosthesis or nursing follow up. In general this would correspond to referral to the family physician in case of the non-beneficiary family. Public Health Service serves as family doctor to many Indians. Where a DIH employed Public Health Nurse is located, additional service to the Indian family is possible.

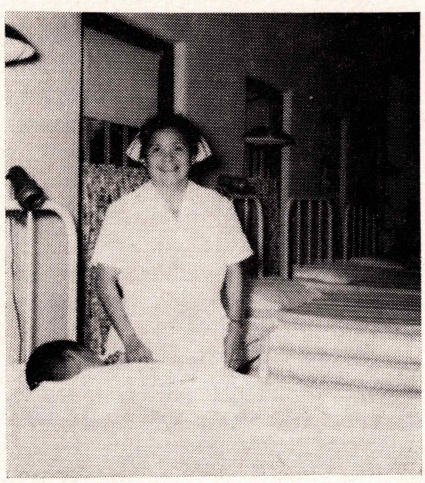
2. DIH consultation services in Health Education and Public Health Nursing are available through arrangements with State Department of Health or Department of Education and the Indian Health Area Office in Oklahoma City.

Miss Bertha Tiber, writer of article on school health in Division of Indian Health, interviews R. E. Fitzgerald, Superintendent of Seneca Indian School. She is headquartered by Public Health Service in Oklahoma to make a special study of PHS services through Division of Indian Health at Bureau of Indian Affairs schools.

3. Participation of Division of Indian Health personnel in special projects may occur. Sometimes Public Health Service nurses work with local Health Department personnel to render service in schools or in community projects. This is always on a non-segregated basis. Where Indians are concerned, Oklahoma exemplifies the PHS philosophy that no child in any school should be treated "different" because of race or religion.

Many of these Indian students in Public Schools do well and go on through highschool and into colleges and fill important posts in industry, in the professions and in government service without the assistance or special benefits that they might claim because of their Indian ancestry. Some of these, especially as they move on into larger population centers, lose their identity as Indians and become acculturated into the life of the community in which they live and work.

However, with the changing pattern of Indian life from that of a rural to an urban economy, and with our rapidly changing social structure, special educational helps are needed for some. For children who can adjust well to public school but live too remote from school, or who come from broken homes, substitute homes are provided. At three locations, BIA maintains dormitories from which they attend public schools. These students participate in local community affairs under the supervision of dormitory personnel. In Oklahoma these locations are Ardmore, Eufaula and Hartshorne.



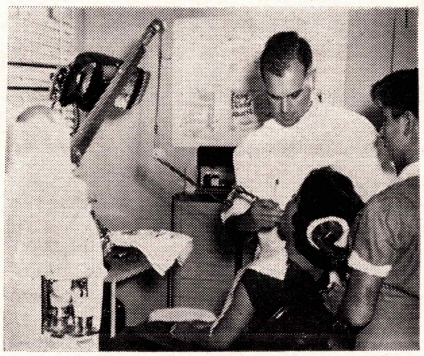
In the boys' ward at Chilocco Indian School, Mrs. Effie Chapman, PHS Staff Nurse, checks the pulse of a little Navajo boy who is ill and far from home. A Caddo-Iroquois, Mrs. Chapman attended Chilocco herself and continued her study to become a registered nurse.

Other Indians of school age find it to their advantage to attend BIA Boarding schools. Here a total program is adapted to prepare them for the life they must face in an environment more complex from that of their home communities. Boarding Schools offer special training in vocational skills and in preparation for entrance to college or professional fields such as nursing. Children from families living in areas socially limited or economically depressed benefit from the transitional stage accorded by living in such a Boarding School. Here a different way of life may be experienced in a secure setting. With the specific vocational training provided, they are thus able to face adult life with more confidence and self sufficiency. There are 6 such Boarding Schools in Oklahoma enrolling about 2200 students annually. These are located at Anadarko, Chilocco, Concho, Lawton, Tahlequah, and Wyandotte. A substantial number of students come from localities outside of the State seeking the special programs offered in the Oklahoma schools. These include Navajo from Arizona and New Mexico and Choctaws from Mississippi for whom school facilities are not available nearer home. Their participation in the school program enriches the experience of their Oklahoma associates and stimulates consideration of wider horizons.

The socially and economically depressed areas from which Boarding School students come are usually deficient in health services. In those localities where services might have been provided, the system of rendering these services may have been paternalistic to a degree that the individual was not inspired to assume much responsibility for his own care. Services would have been available to him as a beneficiary of a benevolent government.

From situations such as these students come to Boarding School. In a very real sense the Division of Indian Health shares with the Bureau of Indian Affairs the responsibility for equipping these young people to face the complexities of life away from their home situations with knowledge and assurance that they can compete successfully with others of their generation.

Just as the BIA dormitory becomes their home and the campus their community, the PHS Center assumes the responsibilities of family physician, family dentist, and Health Department. Special Services must be provided to compensate for past deficiencies. Health supervision appropriate for the age and special needs would compare with that of a conventional school health program, enriched to meet special needs. The student who has physical handicaps is helped to overcome those handicaps or to learn to live with them. The Health Center is staffed with full time professional nursing personnel and part time physicians. Dental service is available to all and is scheduled for all students routinely. Consultation of specialists and hospitalization are available as needed. Consultation of health personnel with classroom and guidance staffs is necessary to insure continuity of care and consistency in health teaching of students. The health status of the individual student is considered in planning his vocational placement.



At Sequoyah, BIA boarding school, PHS Dental Officer on staff of PHS Indian Hospital, Tahlequah, serves the PHS Indian School Health Center. According to Dr. I. J. Jarin, Area Dental Officer, while a student is receptive because of need of care, oral health education is a regular part of treatment. Also, dental officers contribute to special student assemblies with demonstrations and films on diet and home care.

This involves close, continuous communication between PHS and BIA officials. Together, they plan that the experience of each student with the Health Service be a learning experience of the proper order to enable him to take his place in society with confidence and assurance that he understands not only how to maintain his own health, but to support and promote community health activities wherever he may live.

Can Tuberculosis Among Indians Be Eradicated?

DR. JOSE A. SILVA
Assistant Area Medical Officer in Charge
Oklahoma City Indian Health Area

Based on most recent conclusions of the Arden House Conference on Tuberculosis held at Harriman, New York, December 1956, co-sponsored by U.S. Public Health Service and National Tuberculosis Association, we wish to review some important aspects of Indian health today as it affects the nation and Oklahoma.

In the future, tuberculosis associations can think in terms of ERADICATION as an objective, rather than mere control.

The above premise rests heavily on success in work with Indian populations. The extent of the necessity of this work is not yet understood by the general population. I would like to outline briefly the areas, within work with Indians, which have to be stressed to achieve such an objective of tuberculosis eradication.

Tuberculosis sanatoriums are still the most important source of health education and communication needed among Indians concerning eradication of this disease. This is because only in the hospital is the Indian held long enough to teach him the benefits of treatment, the sharp necessity for control of this disease, and how to protect his family when a member has it. In-patient education has been the most successful approach to this, and remains so. Helping any group accept public health concepts is a problem in understanding. Reaching the Indian across his cultural barriers is a unique problem in communication.

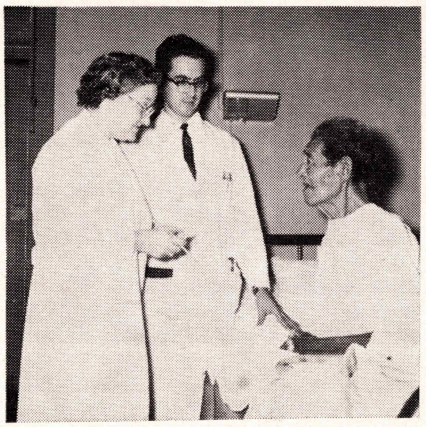
Because tuberculosis is most prevalent among low income groups, individuals having different culture patterns, and groups having low resistance, Indians have figured prominently in the statistics on this disease. Inadequate housing contributes greatly to the low resistance. Crowding, particularly, adds to possibilities in spreading the disease from a carrier.

In present PHS Indian programs there are three factors which must be faced, to succeed. Many people fear diagnosis. *Case-finding* has to reach these people through measures already accepted by them, such as testing at maternal-child health clinics, diabetes clinics, etc. BIA-PHS Indian school programs have made possible much of success with Indians so far. At the new PHS Sanitation Centers it is now possible to inform more Indians of services in TB.

A second factor important is the necessary *follow-up* of carriers who

leave treatment without medical approval. Obtaining adequate follow-up on these with present PHS personnel is a real problem. Follow-up of discharged patients, many needing continuation of a drug program, has been helped with improved PHS Indian Health Stations staffed with Public Health Nurses trained for this service. Some DIH Indian hospitals have clinical social workers to help Indians accept services from state and county organizations doing follow-up on tuberculosis. To strengthen follow-up, it has been very necessary to better the communications between hospitals and nursing stations. All this requires medical records supervision, more clerical personnel, etc. Recent PHS reorganization of Division of Indian Health on what we call the "Service Unit Plan" has as an objective closer ties between Indian hospital and health stations for field work.

Third, we emphasize the necessity to keep physicians up-to-date in the tuberculosis field. The National Tuberculosis Association has provided materials extremely valuable to Indian health workers. The Division of Indian Health has been grateful for these materials because it is through extra doctor education than many of the Indian health programs have been speeded up. Also, younger medical officers coming into Division of Indian Health as Commissioned Officers have not always had the benefit of special training in tuberculosis, and the Association materials are extremely valuable to them in the Indian field. *Extra education for practicing physicians* is a continuing need in Indian Health. We see this as important as the bettering of techniques of reaching the Indian across his cultural barriers.



At PHS Indian Hospital, Lawton, Clinical Social Worker Nan Westmoreland and medical officer visit with an Indian patient. He and his family will be assisted in making best use of community resources available. Problems of the aged are increasing among Indians, as among non-Indians.

Most people are still unaware of the extent to which helping the Indians with tuberculosis protects the general public. However, tuberculosis is just one of the many health fronts among Indians which soon must be conquered if eradication of this disease is the goal.

Social Service in Indian Health's Medical Setting

M. ELISABETH SILCOTT
Area Medical Social Consultant

Social Service in the Division of Indian Health plays an important part in improving health conditions among the Indians of the Oklahoma Area.

Since assignment of the first medical social worker in Indian health to the Shawnee Indian Sanatorium in July 1954, there has been an increasing awareness among health personnel in the Area of the need to assist Indians to find ways to follow a doctor's recommendations, and even to help them understand the need for seeking the attention of a physician when they become ill. There are now five clinical social workers assigned to Oklahoma. Miss Edna Haynes is located at the PHS Indian Hospital, Talihina, Miss Nann Westmoreland at the Lawton Hospital, Mrs. Frances Paxson, Claremore Hospital, and Mr. Armin Saeger at Tahlequah. Mrs. Elisabeth Silcott, Area Medical Social Consultant, is in the Indian Health Area Office in Oklahoma City.

The Indian Health social worker's focus is upon the Indian patient and the social factors which threaten or have affected his health; the social problems which his illness creates for him and his family; and the social, psychological and cultural obstacles which may limit his capacity to make use of medical treatment.

Through direct work services to patients, the social workers help individuals cope with their personal and family problems. Through close working relationships with other social-welfare agencies whose programs affect Indian helath conditions, these workers assist patients in making the best use of the community resources available.

The Social Service Branch plans and carries out a program of medical and psychiatric social services to promote the Public Health Service commitment to advance Indian health. The major functions in this practice of social work include (1) working with individual Indian beneficiaries, their families and groups; (2) participation in policy making and program planning of services to Indians; (3) consultation with Indian health personnel and with Federal, State, and local health, welfare, and educational agencies with regard to problems of Indian beneficiaries; (4) exploration and utilization of resources of community health, welfare, and rehabilitation agencies; (5) recognition and identification of gaps in service coverage of social and health needs as they affect the Indian's well being; and (6) collaboration with re-

lated agencies to close or minimize gaps in services.

The clinical social worker works side by side with doctors, dentists, nurses, occupational therapists, and members of other professions as a member of the medical team when social, psychological, or economic upsets hinder a patient's recovery within the hospital or after he leaves. The social worker meets a wide variety of problems. He often finds himself involved in helping to establish conditions which enable a patient to remain in the hospital, and planning for a patient's discharge, readmission, continuance under medical care, or interfacility transfer. These problems are complicated by the attitudes of individual beneficiaries, or tribes, of the non-Indian community surrounding the Indian, and of people in general toward mental illness, communicable disease, chronic illness or aging.

To cite some examples, a clinical social worker's day might well include helping a patient decide what the best plans are for her out-of wedlock child; locating a place where an elderly man with arrested tuberculosis can live and receive the help he needs; assisting the father of a large family to purchase a surgical belt so that the result of his surgery will be sustained; helping a husband to accept hospitalization as the prescribed plan for his mentally ill wife; helping a young mother make arrangements for her children while she has recommended surgery; helping a patient to realize that while his heart condition is improved, he cannot resume his former mode of living and employment; helping a dying man and his family to make their wishes known to each other despite reluctance to face the possibility of death; or helping an emotionally disturbed patient face his problems and change his attitudes in regard to them.

In addition to serving patients in hospitals and out-patient clinics the social workers assume responsibility for providing services to those Bureau of Indian Affairs boarding school students whose health level is imperiled by their social problems. Early in the fall, hundreds of Indian boys and girls from ages 6 to 20 enter boarding schools located miles away from families and friends. For many, there is little opportunity to see parents or relatives during the school year. Most of these students are admitted to the schools for social reasons. Hence, one might expect to observe, in addition to physical complaints, many emotional disorders emerging as a result of broken homes, long-time deprivations and rejections. Since September 1959, the clinical social workers have spent a considerable portion of their time working directly with students and giving help to boarding school personnel in understanding the needs and behavior of individual students.

The Division of Indian Health social worker represents to the Indian patient and his family a connecting link between the Division of Indian Health and the established social and health agencies in the home community. One of the primary objectives of the Public Health Service achieved through the Division of Indian Health is to assist Indian beneficiaries in the

transition from special Federal health services to private, community, and State health resources. Because of special Indian health needs the Division of Indian Health supplements and reinforces the utilization of community services to the maximum benefit of Indian patients.

Continuous social service liaison and consultation is maintained with such established agencies as the Bureau of Indian Affairs, Public Welfare Departments, Veterans Administration, State Health Departments, Crippled Children's Programs, Child Welfare Division, Vocational Rehabilitation Offices, Tribal Health Committees, and related civic organizations. Such liaison increases understanding of the philosophy and objectives of the Indian health program and enables closer coordination of programs and services. In Oklahoma, the Indian patient and his family have the same entitlement to the services of these agencies as other members of the community. Custom is sometimes confusing, and in some instances, neither Indians nor community agencies realize that the Indian as a citizen has the same rights to community services as the non-Indian. Oklahoma City and Tulsa have developed health programs which include Indians as well as non-Indians in these communities. It is the goal of social service where such consultation is available, to see that no individual who is found to be outside the scope of the Indian health program is turned away from an Indian health facility without being constructively directed to appropriate resource if he needs this guidance.

Community volunteers have been a valuable aid to the Indian health program through supplementary services provided to Indian beneficiaries. These volunteer workers are members of, or affiliated with, officially recognized organizations or community groups, such as the American Red Cross, American Legion or other veterans groups, religious groups, or Indian groups. Examples of their activities include the following: writing letters for patients; reading to patients or making telephone calls for them; distributing books, magazines, cigarettes and toilet articles; shopping and mailing packages; teaching skills and hobby development; and arranging for entertainment and recreation. When such activities are coordinated under supervision of the medical officer and when good communication exists among interested professional groups, patients benefit profoundly.

Social work practice is based on these convictions: (1) that social, emotional, and environmental factors influence the recovery and maintenance of health; (2) that no matter how disabled the beneficiary is, he can be helped to find personal satisfaction in making some contribution as a member of his family or his community; and (3) that lasting results are best assured when the beneficiary and those to whom he is related become freer and surer in using their own resources and strength of personality to clarify and work toward their own fundamental values and goals.

It is this philosophy which guides clinical social workers of the Division of Indian Health in meeting the complex health problems of the Indian beneficiaries in Oklahoma.

Association News

MARGARET SHACKELFORD HONORED BY APHA

At the 1960 APHA annual meeting in San Francisco, Margaret Shackelford was elected to one of three vice-presidential posts. Mrs. Shackelford has served on various committees and councils of APHA including the Statistics Section Council, the Committee on Affiliated Societies and Regional Branches, and the Subcommittee on Educational Qualifications of Public Health Statisticians.

Public health workers throughout the state know her as Director of Statistics, Oklahoma State Department of Health. Along with her state activities, Mrs. Shackelford is president, American Association for Vital Records and Public Health Statistics and a member of the U.S. National Committee on Vital and Health Statistics. Her participation in Oklahoma Public Health Association activities gives our association the benefit of her experience and enthusiasm and we wish her well in this important post. Congratulations!

AMERICAN PUBLIC HEALTH ASSOCIATION ANNUAL MEETING HIGHLIGHTS*

John Shackelford,
Delegate to APHA

The eighty-eighth annual meeting of the American Public Health Association was held in San Francisco October 30, 1960, to November 4, 1960. The Governing Council held its first meeting Sunday afternoon, October 30.

*For detailed information, contact Dr. Shackelford.

New Officers Elected Were:

President-Elect – Charles Glen King, Ph.D. (New York, N. Y.)

Vice-Presidents–G. R. F. Eliot, M.D. (Vancouver, Canada); Humberto Olivero, Jr., (Guatemala City, C. A.); Margaret F. Shackelford, M.S. (Oklahoma City, Okla.)

Treasurer–D. John Lauer, M.D. (New York, N. Y.)

Two members of the Executive Board (three year terms)–Dwight F. Metzler, C.E. (Topeka, Kansas) to succeed himself; Betty W. Bond, Ph.D. (Minneapolis, Minnesota).

Marion W. Sheehan, R.N., President-Elect during the year 1960, moved into the presidency at the second meeting of the Governing Council Wednesday afternoon, November 2.

Executive Board

Dr. John Porterfield, Chairman of the Executive Board, in his report, pointed out that "selection of leadership for the Association is difficult. It is well nigh impossible for any group to know all the possible candidates well enough to choose wisely and repeatedly among them." Two years ago, a committee on committees–now the Committee on Membership Deployment–made up of secretaries of all fourteen sections was set up to assist in selections and to assist in canvassing the membership. It is felt that this is helping.

The Association is looking to a new type of membership for certain health agencies. It is needed for a sound basis of expansion and

for an expanded income in order for the Association to expand its service to members. Dr. Porterfield further stated, "Twenty-five per cent of state health departments have indicated an intention of taking memberships. Eleven states have secured funds and made payment of agency fees. The individual can accomplish little except through the group, and benefits from a professional assocation like ours do not stop with the individual but also have significant values for the organized groups making up our health agencies. The next step will be to offer Agency Membership to those interested non-official agencies who desire in this fashion to benefit by membership in the Association and to support our efforts.

"With regard to Sustaining Memberships, it would seem that the various health related industries of the nation have an ever growing equity in the kind of joint professional planning and standard-setting represented by an organization such as the American Public Health Association."

Planning Methods of Procuring Additional Funds

It was also agreed by the Board during the year after a number of discussions that in the future our appeals to foundations should be on the basis of specific projects of a demonstrational or service type rather than for unearmarked general funds. The 1959 expenditures by the Association were approximately one million dollars, but the budget remained in balance.

Plans for the Future

One special project deserves particular mention. It is the proposed joint effort with the National Health Council to establish a commission on community health services. There is a vital need for a revision of the recommendations and philosophy expressed in the Emerson Report which was titled "Local Health Units for the Nation." There has been an expansion of both the need and demand for certain types of new services and a diminution in both need and demand for other types of traditional public health services. With the National Health Council providing coordination between many related health agencies and with the American Public Health Association providing the professional guidance for this re-evaluation of community needs and services, it should be one of our high priority special projects, providing funds can be secured.

Technical Development Board

Attention was called to new publications in 1960:

Chronic Disease and Rehabilitation: A Program Guide for State and Local Health Agencies.

Guide to a Community Health Study (revised edition).

Services for Children with Heart Disease and Rheumatic Fever.

Planned for publication in 1961:

Administration of Community Health Services;

Control Methods for Mental Disorders;

Guide for the Medical and Public Health Nursing Supervision of Tuberculosis Cases and Contacts (revision);

Health Practice and Indices (revised Evaluation Schedule);

Services for Children with Emotional Disturbances;

Services for Children with Mental Retardation;

Services for Children with Orthopedic Handicaps;

The Role of Public Health Workers and Physicians in Accident Prevention.

These publications serve as excellent guides in public health programs and should be a part of the library of all local health departments.

A Policy Statement submitted by the Technical Development Board and approved as APHA policy position on accidents as a public health problem pointed out that accident prevention "poses a challenge to public health workers equal in scope to the prevention of the infectious diseases and the control of chronic diseases . . . and that the contribution which public health workers can make to accident prevention is believed to be tremendous."

Under study by the Board is a policy statement on medical aspects of rehabilitation. This should be coming out sometime this year. A Guide for Public Health Action in Problem Drinking prepared by Henrik L. Blum, Health Officer of Contra Costa County, California and a Committee of the California Conference of Local Health Officers was recognized as possessing great merit and was circulated among members of the Governing Council.

Committee on Affiliated Societies

Approximately 32 state affiliates and 2 branches were represented at a get-together for representatives of Affiliated Societies and Regional Branches. There was a general discussion of membership, legislation, procedures manuals, programs, and other matters of interest to all affiliates.

Special activities reported on by representatives included:

The Connecticut Public Health Association had prepared and distributed a "Guidebook of Public Health Careers in Connecticut."

New Jersey increased its membership from 300 to 1,000 in one year and has concentrated on presenting a series of three public forums on current health problems.

Washington PHA published a Swimming Pool Operation Manual which carries advertising and sells for $1.25 a copy.

Idaho has published a "Public Health Primer" for lay people.

Massachusetts recently sponsored a legislative symposium where participants studied the "epidemiology of legislation."

There was much interest in Oklahoma's research grants program and the successful public information campaign. An exhibit of materials submitted by affiliates included the Oklahoma Public Health Association letterhead, 1960 annual meeting program, and membership card.

Committee on Evaluation and Standards

Publications which resulted from the work of two sub-committees are:

Ninth Edition of the Control of Communicable Disease in Man;

The Control of Malnutrition in Man, a new volume.

The Subcommittee on Health Aspects of Air Pollution has prepared a manual, "*Local Officials' Guide to Air Pollution Control.*" The Subcommittee has also taken leadership in bringing together several national groups interested in research in relation to air pollution and certain causes of morbidity in the hope that the program

of each organization can be strengthened through interchange of information on projects contemplated and under way.

The Subcommittee on Standards for Multiphasic Screening and Periodic Health Examinations is approaching multiple screening programs first. A study is being made of various methods now in use.

Work of other subcommittees includes two official documents just published:

Standard Methods for the Examination of Dairy Products;

Standard Methods for the Examination of Water and Wastewater.

About to be published is a report *--Diagnostic Procedures and Reagents*, Fourth Edition.

Committee on Public Policy and Legislation

Dr. Herman E. Hilleboe in making this report highlighted the problems of the aged population. The last Congress was concerned almost exclusively with methods of financing care for the aged, whereas the APHA's interest was mainly related to methods for administration of such a program and the need to set standards for high quality medical care. It was recommended that the APHA give continuing attention to the problem and try to formulate realistic, acceptable measures for its solution.

Committee on Constitution and By-Laws

Amendments to the APHA Constitution were proposed and approved by the Governing Council as follows:

1. Making the immediate Past President an officer of the Association, a member of the Executive Board, and a member of the Governing Council for a period of one year following his term as President.
2. Creating a new office, Speaker of the Council, providing for his election by the Governing Council for a three year term of office, and specifying his duties.
3. Deleting the provision giving Governing Council membership to the elective members of the Health Officers' Section Council and thereby equalizing section representation on the Governing Council.
4. Changing wording in several places to make the words "at the close of the annual meeting" consistently used to describe the expiration of terms of office.
5. Increasing a quorum of the Governing Council from 20 to 30.

The benefits of having the retiring President to continue to serve the Association as an officer for an additional year are obvious. The benefits of having a Speaker of the Council are less obvious and need explanation. It is thought that there would be an advantage in having a Speaker of the House to look after the mechanics of presiding so that the President can devote his full attention to the matters under consideration and actively enter discussions when he chooses. The Health Officer's Section itself recommended to the Committee on Constitution and By-Laws that the amendment be offered to reduce their representation on the Governing Council to a number equal with that of other sections. The remaining amendment proposals do not need comment.

Since these proposed amendments were approved by the Governing Council, they will next be published in the *Journal*, and then submitted by mail ballot to the full membership of the Association.

Amendments to the APHA By-Laws were proposed and approved by the Governing Council as follows:

1. Adding the selection of the Speaker of the Council to the duties of the Nominating Committee.
2. Authorizing the Nominating Committee to specify the terms of office of nominees to the Executive Board when there are more than two vacancies to be filled.
3. Providing that any Section, at its discretion, may elect a Secretary-Elect and describe his responsibilities.
4. Providing for Section Councils to fill vacancies in Section offices.
5. Deleting the 75 per cent membership requirement for affiliated societies.
6. Changing wording in several places to make the words "at the close of the annual meeting" consistently used to describe the expiration of terms of office.

These amendments, having been approved by the Governing Council, became effective at the close of the 1960 annual meeting.

ASSOCIATION NEWS

Resolutions passed at the APHA meeting included recommendations on 1959-1961 tabulations of vital statistics data, extension of home nursing service, financial assistance for education programs, financing home care services, control of misleading advertising of health products and services, defense against disaster, strengthening professional public health associations, authority for sanitary control of milk, compulsory pasteurization, federal milk sanitation legislation, world-wide water supply program, programs in mental retardation. Other resolutions included: adequacy and economy in the use of drugs in public medical care programs, enabling legislation for consumer-sponsored prepayment plans, reduction of barriers to licensure of qualified physicians in the states, plastic film products, air pollution control program, provision of essential health services to children without regard to the morality of their parents and endorsement of the Fifth World Conference on Health and Health Education.

Oklahomans selected for Fellowship in the American Public Health Association are: H. Roy Gravelle, D.D.S., Director of Preventive Dentistry, Alex D. Burke, Bacteriologist, Catherine E. Harris, Laboratory Consultant, Oklahoma State Department of Health, Oklahoma City.

Tentative Program

OKLAHOMA PUBLIC HEALTH ASSOCIATION

Twentieth Annual Meeting

Hotel Tulsa **MARCH 8-10, 1961** **Tulsa, Okla.**

FIRST GENERAL SESSION

Registration begins at 9 a.m. each day

Wednesday, March 8 Berl Poe, R.P.S., Presiding

1:30 Call to Order
Invocation
Welcome

2:00 "Planning for the Future"—Kirk T. Mosley, M.D., Oklahoma State Commissioner of Health

3:00 Topic to be announced—T. Glyne Williams, M.D., Medical Director, Oklahoma State Department of Mental Health

4:00 "Accident Prevention"—Paul Joliet, M.D., Deputy Chief, Accident Prevention Program, Public Health Service

SECOND GENERAL SESSION

Thursday, March 9 Berl Poe, Presiding

9:00 "Broad Aspects of Medical Care"—William Schottstaedt, M.D., Chairman, Department of Preventive Medicine, University of Oklahoma Medical Center

10:00 Topic to be announced—Margaret Arnstein, R.N., Chief, Public Health Nursing, Public Health Service

11:00 "Environment and Health"—Tom S. Gable, National Sanitation Foundation, Testing Laboratory, Inc., Ann Arbor, Michigan

SECTION MEETINGS

Thursday Afternoon March 9

THIRD GENERAL SESSION

Friday, March 10 Alice Porter, Presiding

9:00 "A Community Action Formula"—M. L. McDonald, Director, Dallas Health and Science Museum, President-Elect, Southern Branch APHA

10:00 Business Meeting Berl Poe, Presiding

ROOM RATES AT THE HOTEL TULSA:

The Tulsa Hotel has given special rates to those coming to the OPHA meeting. However to qualify for these rates *you must identify yourself as a delegate to the meeting when you register.* FREE PARKING at KC Auto Hotel is provided with hotel registration. The auto hotel is between 3rd and 4th on Cincinnati and parking tickets should be stamped at the Hotel Tulsa registration desk.

Single - - - - - - -	$5.50
Double - - - - - - -	6.25
Twins - - - - - - -	7.75

Three or more to a room—$2.75 per person

News from the Field

CLAREMORE ADVISORY HEALTH COUNCIL

Since is was organized in April, 1955, the Claremore Advisory Health Council has been instrumental in recruiting donors for the local blood bank, in promoting a restaurant ordinance and in laying the ground work for a plumbing ordinance and in improving trash and garbage control.

Other projects include:

1. Fluoridation of water.

2. Establishment of a sanitary landfill.

3. Promotion of the sewer bond issue and planned new sewage plant.

4. Installation of dental unit with the City-County Health Department.

5. Sponsoring of an environmental sanitation survey.

6. Sponsoring a county multiphasic screening program to screen residents for heart and circulatory ailments and other diseases.

In addition to the yearly projects concentrated on by the group, a yearly service is organization of the spring clean-up drive, the immunization survey and sending of letters each month to parents of six-months old children requesting they see their doctors for immunization against the communicable diseases.

"The Health Council works with and has received the full support from the city of Claremore in all of their projects; it has encouraged a variety of projects in which different individuals and groups can work together for the health of our community," according to Dessie Thomas, Rogers County Health Department.

NEW PERSONNEL

Miss Ann Ryan, Public Health Nurse, reported in Oklahoma on October 13, 1960, for assignment in Carter County Health Department. The U. S. Public Health Service assigned Miss Ryan to assist in establishing a visiting nurse service in Carter County. Such services have been available in Oklahoma and Tulsa Counties for several years and to a limited extent through some of the health departments in rural counties. This, however, is the first attempt to set up an organized visiting nurse service outside Oklahoma and Tulsa Counties.

DEATH

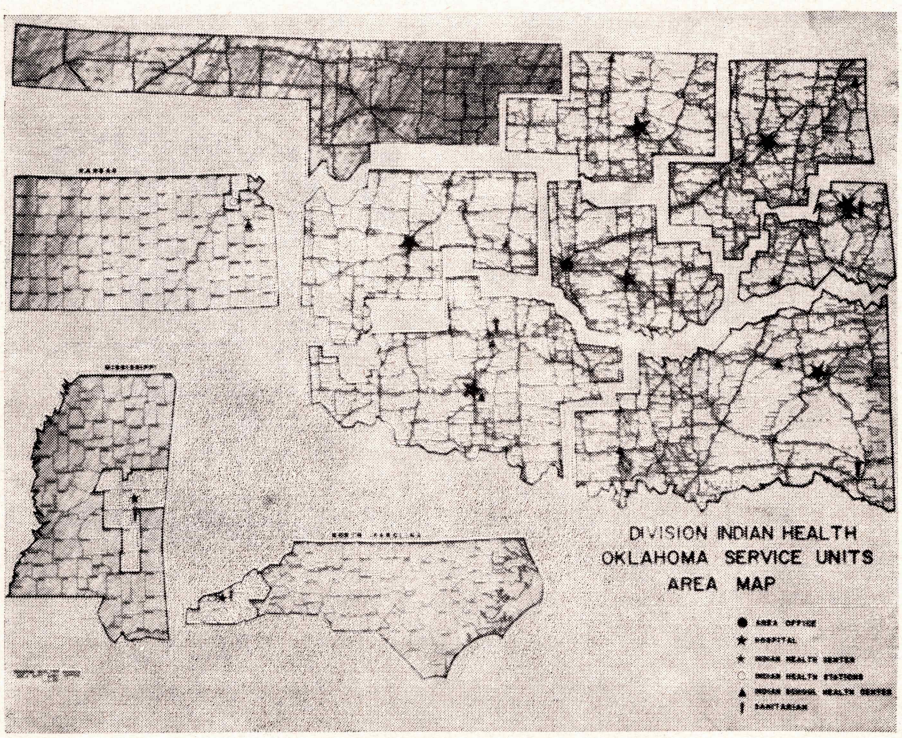
H. A. Shoemaker, Ph.D., Director, Oklahoma Poison Information Center, Oklahoma City, died on November 2, 1960. Founder of the Poison Information Center, Dr. Shoemaker was professor of pharmacology and toxicology at the University of Oklahoma School of Medicine and an active member of OPHA.

PHS and Indians Join Forces . . .

(Continued from Page 11)

is the first law under which Indians not on reservations may obtain help in installing basic sanitation facilities. Oklahoma no longer has reservations, the land being individually allotted. Cherokee and Kickapoo tribes have requested surveys, and signed agreements, and PHS funds have been allocated to aid them in this fiscal year 1960-61.

The design, supervision, and overall guidance of the construction work in Oklahoma under new sanitation legislation is handled by Mr. Edwin L. Dudley, Area Sanitary Engineer, and his staff consisting of Mr. Robert W. Jones, III, Assistant Area Sanitary Engineer, and Mr. Lawrence J. Perez, Jr., Field Sanitary Engineer. Presently there are four PHS Indian Sanitarians who do much of the field work on the projects in Oklahoma. Located in areas of high Indian population are: Earl F. Grinnell, Jr., Wewoka; Leo Roach, Tahlequah; Gabe E. Parker, Idabel; and Gerald Ahpeatone, Anadarko.



HOTEL RESERVATIONS

Return to—HOTEL TULSA, TULSA, OKLAHOMA

Please reserve the following accommodations for the Oklahoma Public Health Association meeting, March 8, 9, and 10, 1961:

(check one desired)

- ☐ Single room at $5.50
- ☐ Double room at $6.25
- ☐ Twin bedroom at $7.75
- ☐ Three or more, at $2.75 per person

Free parking included in above rates.

Arrival date_____ Hr._____ A.M._____ P.M._____

Departure date_____

Name of occupant(s) Address

_____ _____

_____ _____

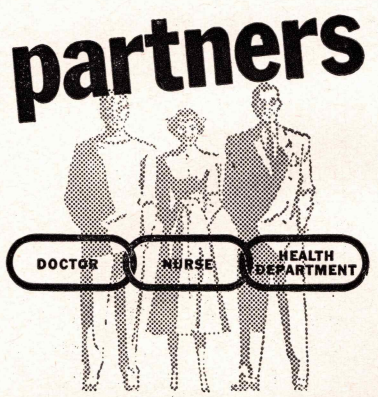
_____ _____

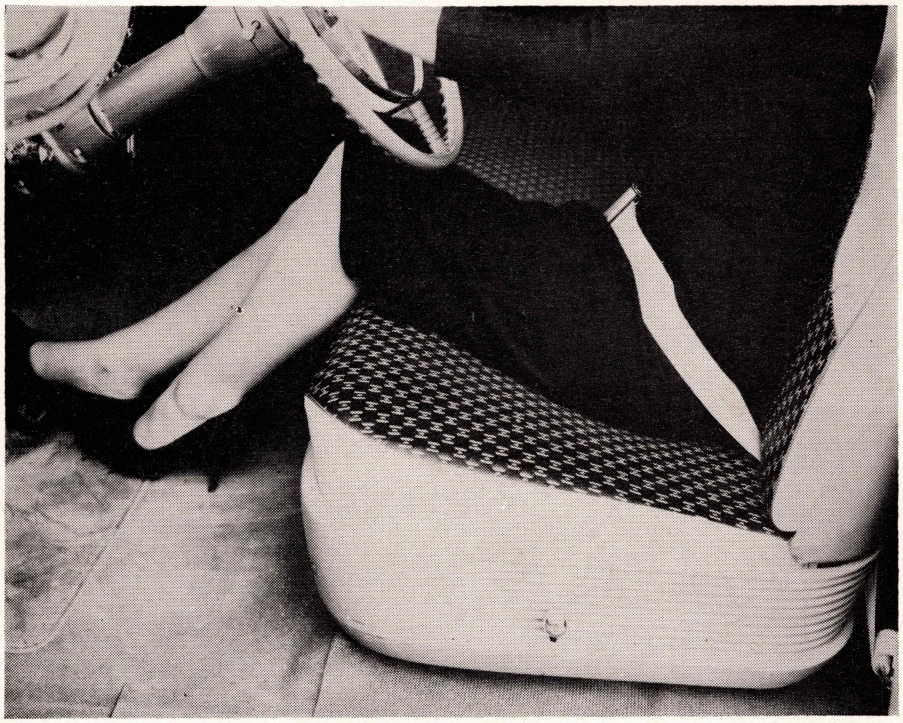
Individual requesting reservations:

NAME_____ ADDRESS_____

"For the first time, public health authorities have an opportunity to determine whether methods used successfully against various diseases will work against the plague we know as the traffic accident."

—Abraham Ribicoff, Governor of Connecticut and future Secretary, Health, Education and Welfare describing the Connecticut Traffic Accident Prevention Study in *Today's Health*.





For highway security—count on safety belts
For financial security—count on

public Health credit union

OKLAHOMA PUBLIC HEALTH ASSOCIATION

Application for Membership:

Name _____

Address (Mailing) _____

Check Section of Primary Interest:

Health Officer ☐ Nursing ☐ Sanitation ☐

Laboratory ☐ Health Education ☐ Clerical and Statistical ☐

Please mail this application with Annual Dues of $3.00 to:

Billy Burk, Secretary-Treasurer
Oklahoma Public Health Association
3400 North Eastern
Oklahoma City 5, Oklahoma