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PERSONAL VIEW

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The Other Poor and Their Children

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THE grape boycott spreads and cries for "La Causa" ring through the Rio Grande Valley, New Mexico, Arizona, Colorado and southern California. Led by Reies Lopez Tijerina, activist Mexican-Americans in New Mexico are attempting to regain land that belonged to their forefathers. Yet during a recent visit to the Navajo Indian reservation, a member of the Tribal Council told me that he wondered what all their fuss was about since the land in question actually belonged to the Indians long before the arrival of the Spaniards or Mexicans. This anecdote gives us an interesting background on the "second" and "third" poverty groups among our minorities.

An American Indian Example

Health problems go hand in hand with poverty. The largest Indian tribe on the mainland U. S. A., the Navajo, is an example of a developing area within our own borders. The 120,000 Navajos reside on a desolate 16 million-acre reservation located in the northeastern part of Arizona, southern Utah and northwestern New Mexico. The demographic features [1] of the people on the Reservation parallel those of developing nations overseas:

Median age	15.5 years (1960)
Birth rate	41.3/1,000 (1966–1968)
Annual population growth rate	2.5 per cent (1967)

The culture and the economic base of sheep and cattle raising has resulted in a rural dispersed population, making distance a tremendously important factor among the health-related problems. Per capita cash income averages approximately $545 per year.[2] One-half the labor force is unemployed.

In 1955, the United States Public Health Service assumed responsibility for medical care on the reservation. Prior to then, this care was rendered by the Bureau of Indian Affairs and several missionary organizations which resulted in minimal and fragmentary health services. Since 1955, the mortality and infectious disease rates have decreased significantly but still range above general U. S. A. figures. Marked gains have been noted in the battles against trachoma, gastroenteritis and tuberculosis.

As Table 1 indicates, accidents constitute the leading cause of death among Navajos. This is a direct result of the rapid social change that these people are experiencing. Only during the last ten years has the culture of surrounding America penetrated the reservation—mainly as a result of paved roads, radio, television and the ability of the Navajo to buy vehicles. The Navajo way of life is family and clan-centered with health strongly woven into the culture. The generation gap in the rest of the U. S. A. is minimal compared with that in Navajo families which are being torn asunder by the desires of the young to live, dress and act like the white man—expressions by Navajo youth of the inaccessibility of the improvements in living readily available to the other inhabitants of this country.

Mental health problems abound, with a resultant high rate of alcoholism. Most fatal accidents are due to high-speed driving combined with alcohol—the end product of rapid social change. Another sign of the huge generation gap is the large numbers of attempted and successful suicides. (Attempted suicide in children as young as ten years old is not uncommon.)

The Navajo infant mortality rate is 45.7 per 1,000 live births (1966).[3] The leading causes of infant hospitalization in 1963 and 1964 were enteric diseases. The leading cause of pediatric hospitalization in 1967 were influenza and pneumonia, gastroenteritis and accidents.

Infant feeding patterns parallel those in other developing nations, with younger Navajo mothers breastfeeding less. As French [4] found, their bottle-fed babies show a higher incidence of diarrhea from birth through one year than breast-fed infants. She noted also that the frequency of hospitalization among bottle-fed babies for the first

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nine months was significantly higher than that of breast-fed babies. Malnutrition is a serious problem. In 1964, 211 preschool children were hospitalized because of malnutrition.[5]

Among chronic conditions, otitis media is the most frequent. An otoscopic survey of more than 3,000 Navajo school children demonstrated the incidence of chronic otitis media to be greater than 7 per cent; this is 15 times greater than the general U. S. population.[6] This high prevalence is attributed to an enhanced susceptibility to respiratory infections which result in acute necrotizing otitis media due to frequent lack of early effective treatment, and to the general poverty of Navajo existence.

Table 2 demonstrates some of the health resources available on the Navajo reservation. These resources must be looked upon in the context of the geography and population characteristics. There are no large towns and the people live in scattered groups. Roads are poor; few people have vehicles, and there is no public transportation. In the Navajo area the U. S. Public Health Service maintains six hospitals with 581 beds and three health centers.

The new Project HOPE–Sage Memorial Hospital Program at Ganado, Ariz., is aimed at Indian self-help. The five-year goal is to have the Navajo community run the hospital.

The Navajos have been on their reservation for 102 years. They have not only been called wards of the federal government, but also have become a completely dependent people, many of whom now lack the desire to be independent. Yet these first Americans are rapidly making themselves heard. Hopefully, some white men are listening to their plight of poverty and ill health and will act to end this national disgrace.

The Rio Grande Valley and Laredo

Hollywood and history have combined to make the Rio Grande Valley and southern Texas seem like an area of romance where cowboys and cattle roamed through cloudless days. Yet for a large portion of the year, the river is shallow and muddy and the words of the song, "As I walked out in the streets of Laredo . . . ," are more appropriate today than when this rapidly growing border city was tiny and dusty. Laredo is a burgeoning city which lies in a zone where 85 per cent of the people are descendants of Mexicans and bring with them that cultural heritage which goes all the way back to old Spain.

The Mexican-American minority group, the second largest poverty group in the U. S. A., extends from Texas across California and up to Colorado. One-sixth of the combined school-age population is Spanish speaking. It may seem incredible but in many of the schools in the Rio Grande Valley, Spanish is not allowed to be spoken.

TABLE 1. *Leading Causes of Death: Comparison of Navajo Indian Reservation with Whole United States*

Cause of Death	Navajo* (1965 to 1967 average)	U. S.* (1966)
Accidents	175.3	58.0
Influenza, pneumonia	62.0	32.5
Malignant neoplasms	56.7	155.1
Diseases of early infancy	56.4	26.4
Diseases of the heart	49.8	371.2
Gastroenteritis, etc.	42.9	3.9
Tuberculosis, all forms	20.7	3.9
Vascular lesions of central nervous system	19.1	104.6
Congenital malformations	18.8	9.3

* Rates per 100,000 population.

Source: Department of Statistics, Indian Health Service, United States Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

With its 80,000 inhabitants, Laredo was listed in 1960 by the U. S. Bureau of the Census as being the poorest city with more than 50,000 population in the U. S. A.[7]

Demographic data show that the median age in 1967 was 18.7 years, and the population growth rate in 1967 was 5.2 per cent.[8] The median family income in 1966 was $3,637 [9] compared to the national average of $6,657.

The poor Mexican-American immigrants in Laredo are an aspiring group, yet low income leads to malnutrition and other maladies. The most disadvantaged area of the city has been chosen for Model Cities improvement. Median annual family

TABLE 2. *Resources for Health Care*: Comparison of Navajo Indian Reservation with Whole United States*

Population per health worker	Navajo** Reservation (1969)	U. S.*** General (1967)
Population per doctor	925	650
Population per graduate nurse (active)	648	333
Population per dentist	4,139	2,005
Beds per 1,000 population	5.5	8.4

* All but three of the hospitals serving the Navajo Area are run by the U. S. Public Health Service—Indian Health Service. Navajos are eligible for treatment in the Indian hospitals of Albuquerque and other cities and in IHS contract hospitals.

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*** World Health Organization: Fourth Report on the World Health Situation 1965–68, Part II, Review by Country and Territory, Geneva, 1970.

TABLE 3. *Resources for Health Care: Comparison of Laredo, Texas, the Whole United States and Peru*

Population per health worker	U. S.** (1967)	Laredo* (1969)	Peru** (1967)
Population per doctor	650	2,228	1,990
Population per dentist	2,005	11,142	6,357
Population per graduate nurse (active)	333	1,300	3,340
Beds per 1,000 population	8.4	3.9	2.4

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** World Health Organization: Fourth Report on the World Health Situation, 1965–68, Part II, Review by Country and Territory. Geneva, 1970.

income here is estimated at $2,000. One-third of all tuberculosis cases reported were in this area. The infant mortality rate is 48.2 deaths per 1,000 births, twice the over-all rate for the city.[10]

Table 3 demonstrates how closely Laredo parallels developing overseas areas in its health manpower.

For both cultural and religious reasons Laredoans have large families. This does take its toll in school. Heller has shown that the difference was as much as ten points between the average I.Q. scores of Mexican-American boys who had only one sibling or none at all, and those who had four or more siblings.[11] Even though the cultural and socioeconomic bias of I.Q. tests is well known, this datum certainly seems significant.

The Laredo–Webb County Health Department and the USPHS Communicable Disease Center have been cooperating in a health demonstration project which has shown already that environmental sanitation emphasis in a specific area can lower the rates of diarrhea.[12] The Laredo–Webb County Health Department is developing new methods of health care delivery through existing teams of public health nurses and community health assistants. They are using the approach that a new system attracts new kinds of manpower; they are reaching into the poorest areas of the city to find promising young candidates who can enter health carers after a basic course at Laredo Junior College which prepares them both to obtain a high school diploma and to work as a nursing assistant in the community. Built into the program is the ladder concept whereby these people may go later into a regular nursing program at the local junior college and afterward continue on upward. The community health assistant is assuming much of the responsibilities of the public health nurse, and the role of the latter is being extended to make health services more available and accessible to families in the area.

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This rapid overview of the health situation of two large representative poverty groups should cause us to examine the major health problem in the United States today, *i.e.*, the distribution of health services. The health crisis is not limited to the large cities, but is nationwide and includes small cities and rural areas alike. Major departures from the present system of health care must be put into action if we are to help these people with their health problems.

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