Arkansas and Southern Branch
APHA Convention

Camelot Inn - Little Rock, Arkansas

REGISTRATION

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Home Address

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Title & Employer

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RECEIPT FOR SOUTHERN BRANCH CONVENTION EXPENDITURES

ACTIVITY	COST	AMOUNT PAID
Pre-registration	$15.00	
On-site Registration	20.00	
One Day Registration	10.00	
Spouse Registration	5.00	
Wed. Nite Entertainment	5.00	
Receipt for Arkansas Convention Expenditures		
Registration	2.00	
Non-member Registration	8.00	
Awards Luncheon	7.00	
Dues	5.00	
TOTAL		

NATIONAL ASSOCIATION OF BLACK SOCIAL WORKERS, INC. 9th Annual Conf. № 653

LAST NAME Small FIRST NAME William T.

ADDRESS Howard University CITY Upper Marlboro STATE MD ZIP 20774

REGISTRATION FEE

$30.00 Non-Student Member, $35.00 Non-Student Non-Member,
$20.00 Student, $20.00 Daily until March 18, 1977.
$35.00 Non-Student Member, $40.00 Non-Student Non-Member
$25.00 Student, $20.00 Daily after March 18, 1977.
$25.00 University/Credit per semester (Additional to Registration Fee)

Only Certified Checks or Money Orders accepted

Students Must Show a Bursar Receipt or Current I.D. Card at the Time of Registration.

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DEPT. Deans Office - Public Health

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✓ 37643	2					
✓	3					
✓	5					
✓	8	2 ea	5X7	gl		7.00
✓ 37637	1					
✓	5					
✓	7					

☐ TRANSPORTATION ______

SPECIAL INSTRUCTIONS: # 7.00

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THE BLACK CAUCUS OF HEALTH WORKERS

OF

THE AMERICAN PUBLIC HEALTH ASSOCIATION

MEMBERSHIP CERTIFIED

FOR

William Small

FOR THE YEAR 1977

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JOHNNY McKOY

President

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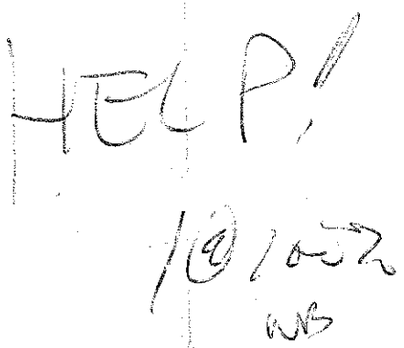
The Black Student Caucus and the Student Union Board of the School of Public Health of the University of North Carolina at Chapel Hill are presenting the first in what we hope will be a series of conferences focusing on the unique and special concerns of minority populations.

The theme of this year's conference is "Perspectives on the Health of Black Populations." We feel that the subject areas chosen for the focus of this conference are of special concern for public health professionals who will be working with black people. A further rationale in the selection of these areas is that we feel sufficient attention has not been given in the courses in the School of Public Health.



WEDNESDAY, MARCH 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Bernard G. Greenberg, Ph.D., Dean
Introduction of Program
Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker
Fred Levick, President, Student Union

Keynote Address
Health, Politics and Economics
Mr. Floyd McKissick, J.D.

10:00 a.m. Break

10:15 a.m. Panel Discussion - *Black Involvement in Health Policy*

Donald Ensley, Ph.D., Moderator

Public Health Practices and Minorities
William Montgomery, Ph.D.

"How the Federal government is addressing issues of equity in manpower"
Clay Simpson, Ph.D.

Black Manpower in the Health Field
E. Lavonia Allison, Ph.D.

12:30 p.m. Lunch

2:00 p.m. Panel Discussion
Institutional & Attitudinal Barriers in Health Care
Cynthia Jenkins, MSW, Moderator

The Impact of Racism
Audreye E. Johnson, D.S.W.

The Role of Folk Medicine
Ruth Dennis, Ph.D.

Blacks as Objects of Experimentation
William Darity, Ph.D.

4:45 p.m. Social Hour - Student Lounge, School of Public Health

THURSDAY, MARCH 31, 1977

Auditorium - Rosenau Hall

10:00 a.m. Panel Discussion:
Rural Health Perspectives
Robert Kelly, MPA, MPH, Moderator

Panelists:
John Hatch, Ph.D.

C. Arden Miller, M.D.

H. Jack Geiger, M.D.

12:00 p.m. Lunch

2:00 p.m. Panel Discussion:
International Health Perspectives
Jeanne Jones, MSW, Moderator

Nutritional Aspects
Joseph Edozien, M.D., Ph.D.

African Perspectives
Glenn Roane, Ph.D.

Jim Lea, Ph.D.

Conference Participants

E. Lavonia Allison
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

William Darity, Ph.D.
Dean
School of Public Health
University of Massachusetts at Amherst

Ruth Dennis, Ph.D.
Professor
Department of Psychiatry
Meharry Medical College

Joseph Edozien, M.D., Ph.D.
Chairman
Department of Nutrition
School of Public Health
University of North Carolina - Chapel Hill

Donald Ensley, Ph.D.
Associate Professor
Department of Community Health
East Cardera University

H. Jack Geiger, M.D.
Chairman and Professor
Department of Community Medicine
State University of N.Y. at Stony Brook

Bernard G. Greenberg, Ph.D.
Dean
School of Public Health
University of North Carolina - Chapel Hill

John Hatch, Ph.D.
Associate Professor
Department of Health Education
School of Public Health
University of North Carolina - Chapel Hill

Cynthia Jenkins
Ph.D. Candidate - Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

Audreye E. Johnson, D.S.W.
Associate Professor
School of Social Work
University of North Carolina - Chapel Hill

Jeanne Jones
Ph.D. Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Robert Kelly
Ph.D. Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Jim Lea, Ph.D.
Director
African Health Training Institutes Project
Carolina Population Center
University of North Carolina - Chapel Hill

Fred Levick
MPH Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Doris Magwood
MPH Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Floyd McKissick, J.D.
President, Soul City Company
Soul City, North Carolina

C. Arden Miller, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

William Montgomery, Ph.D.
Deputy Secretary for Health Systems Development
Pennsylvania Department of Health
Harrisburg, Pennsylvania

Glenn Roane, J.D.
Director
Equal Opportunities Program
Department of State
Washington, D.C.

Earl Siegel, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

Clay Simpson, Ph.D.
Associate Administrator for Health Resources
Opportunity Programs
Health Resources Administration
Public Health Service
Department of Health, Education & Welfare

Sponsoring School
School of Public Health
University of North Carolina at Chapel Hill
Bernard G. Greenberg, Ph.D., Dean

Conference Planning Committee
Janet Miles
Derek Daugherty
Sherry Milan
Doris Magwood
Milton Gunn
Patricia Parker
Rosyland Frazier
William Small

Cover Design: James Neville

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill.

Perspectives On The Health Of Black Populations

March 30 and 31, 1977

FORUM

Perspectives On The Health Of Black Populations

March 30 and 31, 1977

Co-sponsored by the Black Student Caucus and the Student Union Board of the School Of Public Health Of the University of North Carolina at Chapel Hill

~~TENTATIVE PROGRAM~~

Wednesday, March 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Dr. Bernard G. Greenberg, Dean
Introduction of Program - Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker - Fred Levick, President
Student Union

Keynote Address
Mr. Floyd McKissick, J.D.
President, Soul City Company
Soul City, N.C.

10:00 a.m. Break

10:15 a.m. Panel Discussion - Black Involvement in Health Policy

_____ Moderator

Public Health Practices and Minorities - William Montgomery, Ph.D.
Deputy Secretary for Health Systems
Development, Pa. Dept. of Health

~~Issues of Equity in Manpower~~ - Clay Simpson, Ph.D.
"How Federal government is addressing issues of equity in manpower"
Associate Administrator for Health Resources
Opportunity Programs, Health Resources Admin.
Public Health Service, DHEW

Black Manpower in the Health Field - E. Lavonia Allison, Ph.D., Director
North Carolina Health Manpower Corp.

12:30 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - Institutional & Attitudinal Barriers In Health Care

_____ Moderator

The Impact of Racism - Audreye E. Johnson, D.S.W., Associate Professor
School of Soc. Work, Univ. of N.C.

The Role of Folk Medicine - Ruth Dennis, Ph.D., Professor
Dept. of Psychiatry, Meharry Medical College

Blacks as Objects of Experimentation - William Darity, Ph.D., Dean
School of Public Health
Univ. of Mass. at Amherst

4:45 p.m. Social Hour - Student Lounge, School of Public Health

Panelists: title

Audreye E. Johnson, D.S.W.

title

Ruth Deans Phd

title

William Darity Ph.D.

4:45 p.m. Social Hour

Student Lounge, School of Public Health

E. Lavonne Allison, Ph.D.
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

Cynthia Jenkins
Ph. D. candidate - Maternal and child health
SPH
UNC-CH

Audreye E. Johnson, D.S.W.
Associate Professor
School of Social Work
UNC-CH

Ruth Dennis, Ph. D
Professor
Department of Psychiatry
Meharry Medical College

William Darrity Ph.D
Dean
School of Public Health
University of Massachusetts at Amherst

Robert Kelly
Ph. D. candidate HADM
SPH
UNC-CH

John Hatch, Ph. D.
Associate Professor
Department of Health Education
School of Public Health
UNC-CH

Jim Leu, Ph.D.
Director
African Health Training Institutes Project
Carolina Population Center
UNC-CH

Earl Siegel, M.D.
Professor
Dept of MCH
SPH
UNC-CH

The Black Student Caucus and the Student Union Board of the School of Public Health of the University of North Carolina at Chapel Hill are presenting the first, in what we hope will be a series of conferences focusing on the unique and special concerns of minority populations.

The theme of this year's conference is "Perspectives on the Health of Black Populations". The subject areas chosen for the focus of this conference are ~~some which we feel~~ of special concern for public health professionals who will be working with Black people. A further rationale in the selection of these areas is that we feel sufficient attention has not been given in the courses in the School of Public Health to these concerns.

please list w/ addresses etc.

Conference Participants

Bernard G. Greenberg Ph.D
Dean
School of Public Health
University of North Carolina - Chapel Hill

Doris Magwood
MPH candidate - HADM
SPH - spell out
UNC - CH

Fred Leveck
MPH candidate
SPH
UNC - CH

Floyd McKissick, J.D.
President, Soul City Company
Soul City, North Caroline

William Montgomery, Ph.D.
Deputy Secretary for Health Systems Development
Pennsylvania Department of Health
Harrisburg, Pennsylvania

Clay Simpson, Ph.D
Associate Administrator for Health Resources Opportunity Programs
Health Resources Administration
Public Health Service
D.H.E.W.

Donald Ensley, Ph. D.
~~Ph.D. candidate - HADM~~
~~SPH~~
~~UNC - CH~~

C. Arden Miller, M.D.
Professor
Department of Maternal and Child Health
SPH
UNC - CH

H. Jack Geiger, M.D.
Chairmen and Professor
Department of Community Medicine
State Uni. of N.Y. at Stony Brook

Jeanne Jones
Ph.D. candidate - HADM
SPH
UNC - CH

Joseph Edozien M.D. Ph.D
Chairmen
Department of Nutrition
SPH
UNC - CH

Glenn Roane Ph.D.
Director
Equal Opportunities Program
Department of State
Washington, D.C.

Assign seat
Prep Comm reg
Easy reading

Thursday, March 31, 1977 - Auditorium Rosenau Hall

10:00 am - 12:00 pm Panel: Rural Health Perspectives
Moderator: Robert Kelly MPA, MPH
Panelists:
John Hatch, Ph.D
C. Arden Miller, M.D
H. Jack Geiger M.D.

12:00 a.m. - 2:00 p.m. Lunch

2:00 p.m - 4:30 p.m. Panel: International Health Perspectives
Moderator: Jeanne Jones MSW
Panelists:
Joseph Edozien, M.D. Ph.D.
Glenn Roane, Ph.D.
Jim Lea, Ph.D.
Earl Siegel, M.D.

4:30 - 5:00 Concluding Remarks

SPH
logo

Sponsoring School

School of Public Health

University of North Carolina at Chapel Hill

Bernard G. Greenberg, Ph. D., Dean

Conference Planning Committee

Janet Miles

Derek Daugherty

Sherry Milan

Doris Magwood

Milton Gunn

Patricia Parker

Rosyland Frazier

William Small

Cover design: James Neville

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill

Wednesday, March 30, 1977 - Auditorium Rosenau Hall

9:00 a.m. - 9:10 a.m. Welcoming Remarks
Bernard G. Greenberg, Ph.D
Dean

9:10 am - 9:20 a.m. Opening of the Conference
Dana Maywood, Chairperson
Black Student Caucus

9:20 am - 10:00 am. Introduction of Keynote Speaker
Fred Lewick, President
Student Union

Keynote Address
title
Mr. Floyd McKissick J.D.

10:00 am - 10:15 a.m. Break

10:15 am - 12:30 p.m. Panel: Black Involvement in Health Policy
Moderator: Donald Ensley Ph.D.
Panelists: title
William Montgomery, Ph.D
title
Clay Simpson, Ph.D
title
E. Lavinia Allison, Ph.D.

12:30 pm - 2:00 p.m. Lunch

2:00 pm - 4:15 p.m. Panel: Institutional and Attitudinal Barriers in Health Care
Moderator. Cynthia Jenkins MSW

~~TENTATIVE PROGRAM~~

Thursday, March 31, 1977 — 10 B A/C

Auditorium - Rosenau Hall — 10 B W

9:30 a.m. Panel Discussion - Rural Health Perspectives

_____ Moderator

Panelists - John Hatch, Ph.D., Associate Professor
Dept. of Health Education
School of Public Health, Univ. of N.C.

C. Arden Miller, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

H. Jack Geiger, M.D., Professor & Chairman
Dept. of Community Medicine
State University of New York at Stony Brook

12:30 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - International Health Perspectives

_____ Moderator

Nutritional Aspects - Joseph Edozien, M.D., Ph.D., Chairman
Dept. of Nutrition
School of Public Health, Univ. of N.C.

African Perspectives - Glenn Roane, Ph.D.
Former Director of Regional Population Office for Africa U.S. Agency for International Development
Washington, D.C.

Jim Lea, Ph.D., Director
African Health Training Institutes Project
Carolina Population Center, Univ. of N.C.

Carribean Perspectives - Earl Siegel, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

4:30 p.m. Adjourn

Conference Participants

E. Lavonia Allison
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

William Darity, Ph. D.
Dean
School of Public Health
University of Massachusettes at Amherst

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Dept. Comm. Health
East Cardera Uni.

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University of North Carolina - Chapel Hill

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Associate Professor
School of Social Work
UNC-Ch

Jeanne Jones
Ph.D. Candidate - HADM
SPH
UNC-Ch

Robert Kelly
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SPH
UNC-Ch

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Sponsoring School

School of Public Health
University of North Carolina at Chapel Hill
Bernard G. Greenberg, Ph. D., Dean

Conference Planning Committee

Janet Miles
Derek Daugherty
Sherry Milan
Doris Magwood
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Cover Design: James Neville

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Department of State
Washington, D.C.

Earl Siegel, M.D.
Professor
Department of MCH
SPH
UNC-Ch

Clay Simpson, Ph.D.
Associate Administrator for Health Resources Opportunity Programs
Health Resources Administration
Public Health Service
D.H.E.W.

March 23, 1977

Projected Budget for March 30 & 31 Conference

Travel for out-of-town presenters (standard roundtrip airfares quoted by Continental Travels)

New York, N.Y.	$114.00	
Harrisburg, Pa.	98.00	
Hartford, Conn.	136.00	
Nashville, Tenn.	126.00	
Washington, D.C.	80.00	
Cabs & Tips	60.00	6 @ $10.00
Total Travel	$608.00	---- $610.00

Lodging - Carolina Inn or Comparable facility

6 rooms	$100.00	@ $15.00 + taxes medium priced
Meals	90.00	@ 15.00
Total	$190.00	will give $30.00 for each participant

Coffee & Social Hour

Coffee and/coke for break	$30.00	← 3lbs. 8x3 = $24 coffee
Social Hour	30.00	
Relish tray & nuts	20.00	
Cups & napkins	20.00	
Total	100.00	

Advertisement & Miscellaneous

Posters	$15.00	
Handbills	35.00	
Mailing	20.00	(D.O.)
Program printing	70.00	
	$140.00	

Honorarium	$750.00	5 @ $150.00
Miscellaneous	200.00	
Total	1988.00	----------$2000.00

URBAN HEALTH
THE JOURNAL OF HEALTH CARE IN THE CITIES

March 7, 1977

Mr. William T. Small
Assistant Dean
The University of North Carolina
School of Public Health
Chapel Hill, N.C. 27514

Dear Mr. Small:

Thank you very much for the notice on the forthcoming conference on "Perspectives on the Health of Black Populations."

Because of some other travel commitments, it will not be possible for me to attend. However, we would like to have a news release following the conference, and a photo, to carry in the June issue of this journal. Perhaps a photo of the panel featuring Drs. Ensley, Montgomery, Simpson and Lavonia Allison.would be good if you plan to have a photographer at the event.

I hope that the meeting is successful.

Yours truly,

Harold Hamilton

Harold Hamilton
Publisher

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Conf

1124-3rd Street, S.W.
Washington, D.C. 20024
March 6, 1979

W. T. Small, Assistant Dean
School of Public Health
University of North Carolina
at Chapel Hill
Rosenau Hall 201 H
Chapel Hill, North Carolina 27514

Dear Mr. Small:

Thank you for your letter of February 7, 1979, concerning the third annual Minority Health Conference. I am sorry that I was not able to attend the conference. I am interested in the School of Public Health at the University of North Carolina and thus there are a number of questions that are unanswered.

I looked through the bulletin which you sent me and found a program that I am particularly interested in. This program being that of Maternal and Child Health. I understand that one needs two-years of experience in that area before they can be admitted. I am interested in this field but I don't have the experience because I just recently graduated in September 1978. Do you have a program in General Public Health where I can gain academic experience in this area without having this experience.

Any assistance that you are able to provide will be greatly appreciated.

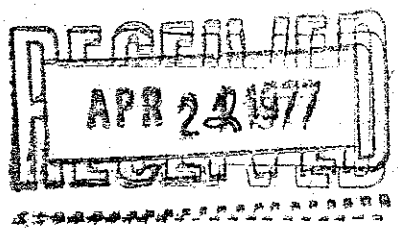
Very truly yours,

Lisa L. Zackery
(202) 484-0495

North Carolina Health Manpower Development Program
Room 201, NCNB Plaza
136 East Rosemary Street - 322A
Chapel Hill, N.C. 27514

Dr. E. Lavonia Allison
Director

Phones: (919) 966-2264
(919) 966-2265



April 20, 1977

Mr. William T. Small
Assistant Dean
School of Public Health
140 Rosenau Hall, 201H
CAROLINA CAMPUS

Dear Bill:

This is to acknowledge receipt of your letter of April 14, 1977. It was surely my pleasure to have the opportunity to serve as a panelist during the recent conference, "Perspectives on the Health of Black Populations".

A formal manuscript was not used for my presentation; however, enclosed is a copy of an Overview of NCHMDP from which major parts of my presentation were taken. Also enclosed are copies of the transparencies that made up the visual parts of my presentation. Hopefully the materials provided will be helpful in the compilation of the proceedings as related to my presentation.

I look forward to receiving a copy of the proceedings.

Very sincerely yours,

Lavonia

E. Lavonia Allison
Director

mr

Enclosures - Overview of NCHMDP
Statistical Data of Presentation

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

O V E R V I E W

The North Carolina Health Manpower Development Program (NCHMDP) was organized in 1971 as a consortium of educational institutins and community health services agencies to address the state's shortage of health manpower -- especially in minority and disadvantaged communities. In 1974, NCHMDP became an inter-institutional program of the University of North Carolina System, operating under the aegis of UNC-Chapel Hill and responsible to the Vice Chancellor for Health Affairs.

NCHMDP consists of a Central Office in Chapel Hill; three regional centers at North Carolina Central University, Elizabeth City State University, and Pembroke State University; and a 32-member Health Manpower Advisory Council with representatives from educational institutions, public and private health agencies and societies, health employers, and community health consumers.

North Carolina is presently far behind the national average in almost every category of health manpower. Nationally, there is one physician for every 775 persons while North Carolina has only one physician for every 1,020 persons. In optometry, there is one practitioner for every 10,554 persons nationally. In North Carolina that ratio is 1:15,241. The nation has a ratio of 1:28,541 in podiatry while North Carolina's ratio is 1:213,375. The trend continues, unfortunately, in the allied health professions where the state's ratio of practitioners to population is consistently higher than the national ratio.

For the state's minorities and disadvantaged, the figures are even worse. While the national ratio of minority physicians to the minority

population is 1:3,824, North Carolina records a ratio almost twice as high -- 1:7,375. In optometry, the minority ratio is 1:228,901 for the nation and 1:293,147 for the state. The most telling statistic is in podiatry where there is no minority representation in the state. Statistics on other health professions are presented in Fact Sheet #1.

The figures for minority health manpower in the state are even more revealing when one considers the fact that North Carolina has the sixth largest black population in the nation and is the home of more predominantly minority four-year institutions (11) than any other state in the U.S. These 11 institutions enroll approximately 21,000 students and when combined with minority students enrolled in the state's other public and private 48 institutions it constitutes a formidable resource within the state. Also deserving mention is the state's American Indian population, which is the fifth highest of any state, whose representation in the health professions is practically nil.

The reasons for the serious underrepresentation of minorities in all seven health disciplines (MODVOPP) as well as in the other professional areas such as nursing, public health, and allied health are both complex and varied. Many minority students in North Carolina have not been afforded an equality of educational opportunity that would enhance their competitiveness in the admission/selection process to undergraduate health training programs and to health professional schools. They have also had limited exposure to a broad range of role-models representing the many health career opportunities for which training is available in North Carolina and in other programs not offered in North Carolina, such as optometry, podiatry, osteopathy, and veterinary medicine. Complicating the problem is the impression that health training and professional programs require a lengthy and costly educational

process. There is also the lack of awareness on the part of many minority students that health careers are available in a broad range of fields requiring as little as one year post-secondary training to as many as 12-15 years training (M.D. specialty).

To address this problem, NCHMDP has a multi-purpose program designed to: (1) increase the number of minority and disadvantaged persons being trained and employed in health careers; (2) increase the availability of health services to minority and disadvantaged communities; (3) increase the commitment on the part of all service agencies on behalf of improved health care to minority and disadvantaged communities; (4) improve the quality of health care delivery and services for minority and disadvantaged persons.

To accomplish its goals, NCHMDP provides: general informatin on more than 200 health careers and specific information on health training programs in North Carolina and other states; health career counseling on prerequisites for admission, standardized tests required, and procedures for applying to health training programs; assistance to students applying to health training programs, an advocate service for their admission, and referrals when needed; information about appropriate sources of financial assistance for students in health training programs; academic skills development materials and health sciences self-instructional programs to guidance counselors, health occupations teachers, and health science faculty members at post-secondary institutions; a health career film loan service; and a Clinical Work-Study Summer Health Program that offers clinical and academic enrichment experiences for minority and disadvantaged college students enrolled in a health or health-related curriculum.

NCHMDP also publishes a quarterly newsletter, ACTION, which is distributed to approximately 4,000 individuals, agencies, and societies, including counselors at all of the state's junior and senior high schools and pre-professional counselors in the 16 Institutions Health Sciences Consortium; distributes a directory of pre-medical and pre-dental summer academic enrichment programs to pre-professional advisors and minority students; offers an employment referral service for minority health professionals; maintains a working directory on more than 200 health training programs; and sponsors workshops for health science faculty members from the predominantly minority institutions in the 16 Institutions Health Sciences Consortium, for the purpose of introducing faculty members to methods for improving students' skills and abilities in the basic sciences required as prerequisites for admission to health professional programs.

During 1975-76, NCHMDP activities showed marked increases, especially

North Carolina Health Manpower Development Program

"Increasing minority health manpower"

GOALS

1. To increase the number of minority persons trained and employed in health careers
2. To increase the availability and improve the quality of health care in minority communities
3. To increase official commitment to improvement of health services for minority people

ACTIVITIES

STATEWIDE INFORMATION AND COMMUNICATION NETWORK

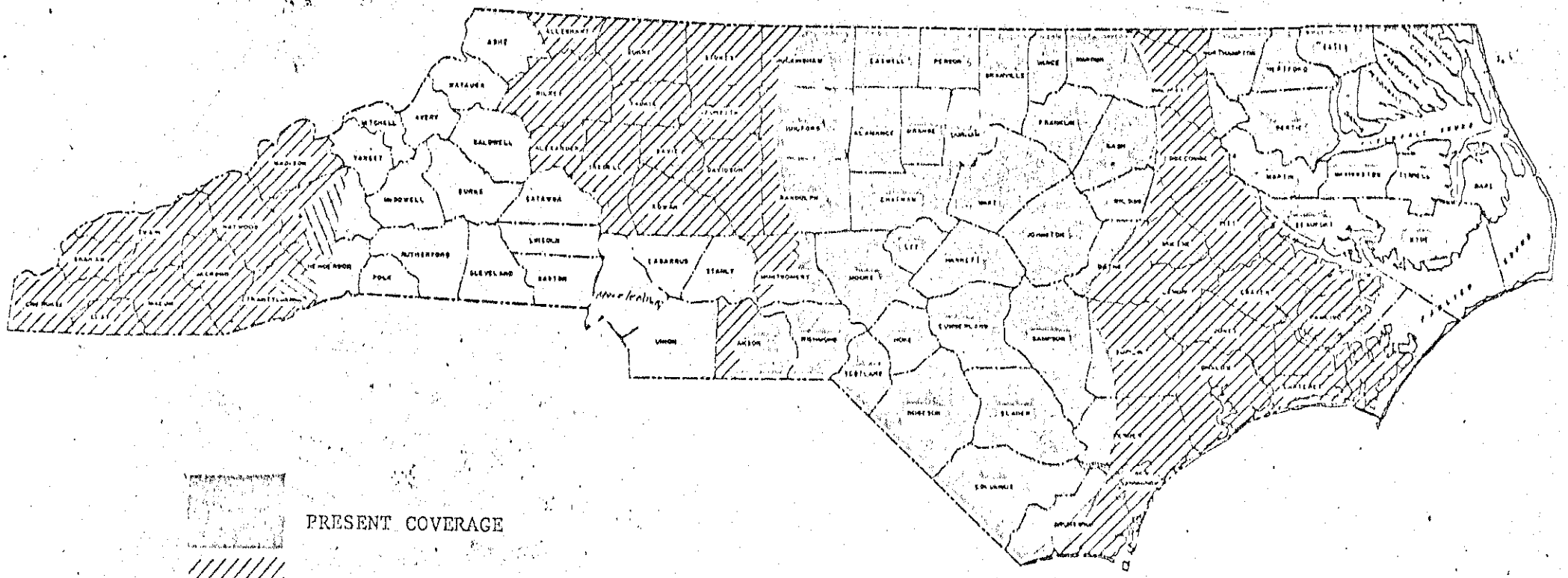
General
Specific health careers
T.I.
UG.
Grad.
Prof.

ACTION newsletter
Workshops
CWSSHP
Counseling
Community assistance NHSC

NCHMD
central office
regional centers
psu
nccu
unc
ecsu
SC
GA
TENN
VA

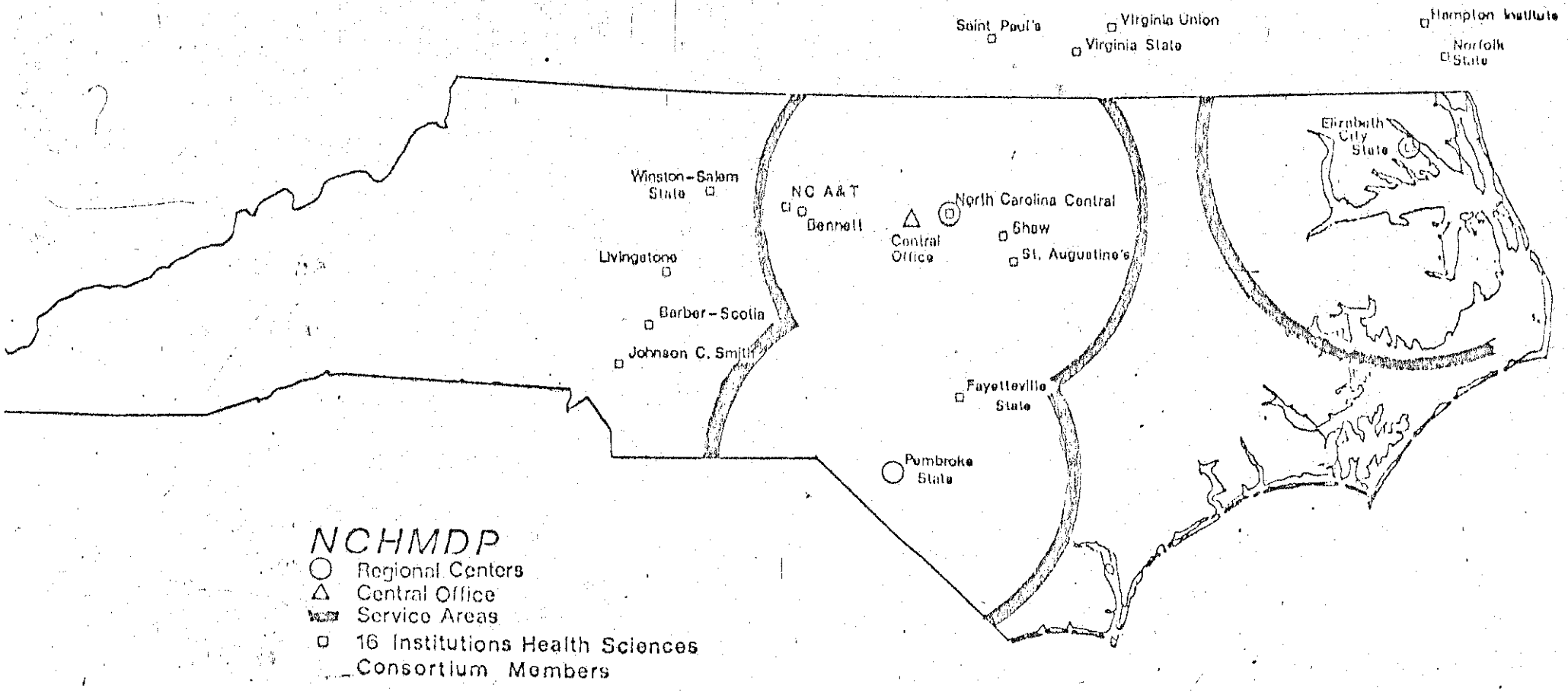
NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

GEOGRAPHIC REGIONS OF NCHMDP HEALTH CAREERS RECRUITMENT, COUNSELING, AND RETENTION SERVICES



PRESENT COVERAGE

PROPOSED EXTENDED COVERAGE


Saint Paul's
Virginia Union
Virginia State
Hampton Institute
Norfolk State
Elizabeth City State
Winston-Salem State
NC A&T
Bennett
Central Office
North Carolina Central
Shaw
St. Augustine's
Livingstone
Barber-Scotia
Johnson C. Smith
Fayetteville State
Pembroke State
NCHMDP
Regional Centers
Central Office
Service Areas
16 Institutions Health Sciences
Consortium Members

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

	Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employed
PHYSICIANS:							
U.S.	**291,222	6,106	2%	1:775	1:3,824	1:673	1:47
N.C.	5,039	159	3%	1:1,020	1:7,375	1:861	1:32
DENTISTS:							
U.S.	91,025	2,098	2%	1:2,380	1:11,129	1:2,038	1:43
N.C.	1,421	58	4%	1:3,655	1:20,217	1:2,998	1:26
OPTOMETRISTS:							
U.S.	19,254	102	.5%	1:10,554	1:228,901	1:9,549	1:188
N.C.	336	4	1%	1:15,241	1:293,147	1:12,031	1:84
PHARMACISTS:							
U.S.	109,642	2,501	2%	1:1,853	1:9,335	1:1,662	1:44
N.C.	2,043	64	3%	1:2,506	1:18,322	1:2,018	1:32
PODIATRISTS:							
1/U.S.	7,120	223	3%	1:28,541	1:104,699	1:25,823	1:32
2/N.C.	24	-0-	0%	1:213,375	0:1,172,589	1:166,438	0:24
3/**R.N.'s:**							
U.S.	829,691	62,335	8%	1:245	1:375	1:232	1:13
N.C.	17,565	1,886	11%	1:292	1:622	1:255	1:9
VETERINARIANS:							
U.S.	19,435	252	1%	1:10,456	1:92,651	1:9,284	1:77
N.C.	315	6	2%	1:16,357	1:195,432	1:12,927	1:53

* Blacks and Native Americans only

** All figures, except where noted, from Minorities & Women in the Health Fields, DHEW, September 1975

1/ Figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

2/ Figures from National Podiatry Association Newsletter, Vol. 3, February 1976

3/ Includes graduates of all R.N. programs

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

	Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employed
DIETITIANS:							
U.S. **	40,225	7,469	19%	1:5,052	1:3,126	1:5,420	1:5
N.C. ***	1,251	351	28%	1:4,094	1:3,340	1:4,438	1:4
CLINICAL LAB.:							
U.S.	118,264	11,179	9%	1:1,718	1:2,089	1:1,661	1:11
N.C.	2,156	287	13%	1:2,375	1:4,085	1:2,150	1:8
DENTAL HYG.:							
U.S.	17,458	301	2%	1:11,640	1:77,568	1:10,381	1:58
N.C.	238	-0-	0%	1:21,517	0:1,172,589	1:16,784	0:238
DENTAL ASST.:							
U.S.	90,497	3,337	4%	1:2,246	1:6,997	1:2,043	1:27
N.C.	1,740	79	5%	1:2,943	1:14,843	1:2,405	1:22
DENTAL LAB. TECH.:							
U.S.	26,810	1,476	6%	1:7,580	1:15,818	1:7,030	1:18
N.C.	322	33	10%	1:15,904	1:35,533	1:13,822	1:10
HEALTH ADM.:							
U.S.	84,461	4,166	5%	1:2,405	1:5,604	1:2,218	1:20
N.C.	1,879	168	9%	1:2,725	1:6,980	1:2,335	1:11
HEALTH REC.:							
U.S.	10,946	547	5%	1:18,565	1:42,684	1:17,127	1:20
N.C.	199	9	5%	1:25,734	1:130,286	1:20,073	1:22

* Blacks and Native Americans only

** U.S. figures from Minorities and Women in the Health Fields, DHEW, September 1975

*** N.C. figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

		Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employ
LAY MIDWIVES:								
U.S.	**	941	375	40%	1:215,954	1:62,261	1:314,677	1:3
N.C.	***	36	30	83%	1:142,250	1:39,086	1:665,750	1:1
NURSING AIDES, ORDERLIES, ATTND.:								
U.S.		723,576	187,523	26%	1:281	1:125	1:332	1:4
N.C.		14,356	6,118	43%	1:357	1:192	1:485	1:2
PRACT. NURSES:								
U.S.		235,546	52,306	22%	1:863	1:446	1:972	1:5
N.C.		4,218	1,181	28%	1:1,214	1:993	1:1,315	1:4
OPTICIANS, LENS GRINDERS, POLISH.:								
U.S.		27,844	1,215	4%	1:7,298	1:19,216	1:6,688	1:23
N.C.		367	14	4%	1:13,954	1:83,756	1:11,316	1:26
RADIOLOGIC:								
U.S.		52,566	3,676	7%	1:3,866	1:6,351	1:3,643	1:14
N.C.		893	80	9%	1:5,734	1:14,657	1:4,913	1:11

* Blacks and Native Americans only
** U.S. figures from Minorities and Women in the Health Fields, DHEW, September 1975
*** N.C. figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

MINORITY ENROLLMENT, UNC-CHAPEL HILL, HEALTH AFFAIRS, FALL 1976 NCHMOP

SCHOOL	TOTAL ENROLLMENT	BLACK / %	AMERICAN INDIAN / %	TOTAL MINORITY ENROLLMENT /
MEDICINE	560	77 / 13.8%	12 / 2.1%	89 / 15.9%
DENTISTRY	328	13 / 3.9%	4 / 1.2%	17 / 5.2%
PHARMACY	582	22 / 3.8%	1 / .12%	23 / 3.9%
PUBLIC HEALTH	512	50 / 9.8%	4 / .78%	54 / 10.5%
MED. TECH.	24	2 / 8.3%	0 / 0.0%	2 / 8.3%
PHYS. THERAPY	48	3 / 6.2%	1 / 2.0%	4 / 8.3%
RADIOLOGY	3	1 / 33.3%	0 / 0.0%	1 / 33.3%
DENTAL HYGIENE	139	2 / 1.4%	0 / 0.0%	2 / 1.4%
NURSING	292	15 / 5.1%	2 / .68%	17 / 5.8%
TOTALS	2,448	185 / 7.6%	24 / .98%	209 / 8.5%

HEADCOUNT ENROLLMENT AND GRADUATES UNC-CH 1975-76

FACT SHEET #3

SCHOOLS	SIZE OF ENTERING CLASS	BLACK			AMERICAN INDIAN			TOTAL MINORITY ENROLLMENT			ALL OTHER			TOTAL ENROLLMENT			GRADUATES			MINORITY GRADUATES							
																				BLACKS			INDIANS			TOTAL	
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
TISTRY)	83 (83)	8	2	10	1	1	2	9	3	12	285	29	314	294	32	326	78	2	80	0	0	0	0	0	0	0	0
CINE	140 (160)	48	23	71	6	2	8	54	25	79	359	85	444	413	110	523	96	27	123	8	6	14	0	0	0	9	5
IC HEALTH	217 (280)	26	27	53	4	1	5	30	28	58	264	240	504	294	868	662	125	112	237	7	11	18	2	0	2	9	11
MACY dergrad.)	159 (160)	11	10	21	2	1	3	13	11	24	294	276	570	307	287	594	80	63	143	3	1	4	1	0	1	4	1
MACY ad.)		0	0	0	0	0	0	0	0	0	10	6	16	10	6	16	5	6	11	0	0	0	0	0	0	0	0
ICAL HNOLOGY	(24)	0	1	1	0	0	0	0	1	1	2	21	23	2	22	24	2	22	24	0	1	1	0	0	0	0	1
SICAL RAPY	(24)	0	3	3	0	0	0	0	3	3	7	36	43	7	39	46	4	18	22	0	2	2	0	0	0	0	2
ICLOGIC ENCE	5 (12)	1	0	1	0	0	0	1	0	1	0	4	4	1	4	5	0	0	0	0	0	0	0	0	0	0	0
IOLOGIC HNOLOGY	Term, Cert, Prog.	0	0	0	0	0	0	0	0	0	2	5	7	2	5	7	2	5	7	0	0	0	0	0	0	0	0
TAL HYGIENE dergrad, Cert,)	(50)	0	1	1	0	0	0	0	1	1	0	113	113	0	114	114	0	62	62	0	0	0	0	0	0	0	0
..T.E.	(10)	0	0	0	0	0	0	0	0	0	1	22	23	1	22	23	0	9	9	0	0	0	0	0	0	0	0
TAL LISTING	(60)	1	4	5	0	0	0	1	4	5	0	48	48	1	52	53	1	50	51	1	3	4	0	0	0	1	1
SING dergrad.)	(150)	0	16	16	0	0	0	0	16	16	13	267	280	13	283	296	4	127	131	0	10	10	0	0	0	0	1

MEDICAL SCHOOL ENROLLMENT — SELECTED YEARS

NCHMDP

FIRST YEAR CLASS

UNITED STATES	Total	Black	%	NORTH CAROLINA	Total	Black	%
1974-75	14,763	1,106	7.5	1974-75	343	39	11.4
1975-76	15,295	1,036	6.8	1975-76	360	41	11.0

TOTAL ENROLLMENT

UNITED STATES	Total	Black	%	NORTH CAROLINA	Total	Black	%
1974-75	53,554	3,355	6.3	1974-75	1,303	103	7.9
1975-76	55,818	3,456	6.2	1975-76	1,377	119	8.6

MEDICAL SCHOOL ENROLLMENT — N. C. SCHOOLS

Bowman Gray (BG) Duke (DU) UNC - Chapel Hill (UNC)

FIRST YEAR CLASS

	Total	Black	%		Total	Black	%
1974-75	90 (BG)	8	8.8	1975-76	101 (BG)	7	6.9
	122 (DU)	10	8.2		119 (DU)	12	10.0
	131 (UNC)	21	15.7		140 (UNC)	22	15.7
	343	39	11.0		360	41	11.0

TOTAL ENROLLMENT

	Total	Black	%		Total	Black	%
1974-75	347 (BG)	20	5.7	1975-76	369 (BG)	19	5.1
	462 (DU)	27	5.9		485 (DU)	31	6.4
	494 (UNC)	56	11.4		523 (UNC)	69	13.2
	1,303	103	7.9		1,377	119	8.6

DENTAL SCHOOL ENROLLMENT, 1976-1977

UNITED STATES

YEAR	TOTAL	BLACK	% OF BLACK ENROLLMENT
1ST	5,935	291	4.9
2ND	5,616	237	4.2
3RD	4,235	220	5.1
4TH	5,227	207	3.9
	21,013	955	4.5

NORTH CAROLINA

YEAR	TOTAL	BLACK	% OF BLACK ENROLLMENT
1ST	84	3	3.6
2ND	82	4	4.8
3RD	81	4	4.8
4TH	78	2	2.6
	325	13	4.0

DENTAL SCHOOL GRADUATES, 1976

UNITED STATES

TOTAL	BLACK	% OF BLACK GRADUATES
5;336	213	3.9

NORTH CAROLINA

TOTAL	BLACK	% OF BLACK GRADUATES
80	0	0.0

Arkansas and Southern Branch
APHA Convention

Camelot Inn - Little Rock, Arkansas

REGISTRATION

Name and degree (Please Print)

Home Address

City State Zip Code

Title & Employer

Section Affiliation

RECEIPT FOR SOUTHERN BRANCH CONVENTION EXPENDITURES

ACTIVITY	COST	AMOUNT PAID
Pre-registration	$15.00	
On-site Registration	20.00	
One Day Registration	10.00	
Spouse Registration	5.00	
Wed. Nite Entertainment	5.00	
Receipt for Arkansas Convention Expenditures		
Registration	2.00	
Non-member Registration	8.00	
Awards Luncheon	7.00	
Dues	5.00	
TOTAL		

NATIONAL ASSOCIATION OF BLACK SOCIAL WORKERS, INC. 9th Annual Conf. № 653

LAST NAME Small FIRST NAME William T.

ADDRESS Howard University CITY Upper Marlboro STATE MD ZIP 20774

REGISTRATION FEE

$30.00 Non-Student Member, $35.00 Non-Student Non-Member,
$20.00 Student, $20.00 Daily until March 18, 1977.
$35.00 Non-Student Member, $40.00 Non-Student Non-Member
$25.00 Student, $20.00 Daily after March 18, 1977.
$25.00 University/Credit per semester (Additional to Registration Fee)

Only Certified Checks or Money Orders accepted

Students Must Show a Bursar Receipt or Current I.D. Card at the Time of Registration.

AMOUNT PAID	$ 35.00	Check No. 28656	Date 3/28/77

PLEASE BRING THIS RECEIPT WITH YOU AT TIME OF CONFERENCE

JOHN ADAMS, *National Treasurer*
2008 Madison Avenue, New York, N.Y. 10035

Not responsible for work left over 30 days

UNIVERSITY OF NORTH CAROLINA
COMMUNICATION CENTER PHOTO LAB 61113 Ext. 20

DATE 6-9-77 DELIVERY DATE 6-13-77

NAME William T. Small

DEPT. Deans Office - Public Health

ACCOUNT 1-2-101-4601-3919

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NO. OF SHOTS ________ ☐ NIGHT ☐ DAY

NEGATIVE NUMBER	PRINTS FRAME	NO. EACH	SIZE	FINISH	OTHER	PRICE
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✓	3					
✓	5					
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✓ 37637	1					
✓	5					
✓	7					

☐ TRANSPORTATION

SPECIAL INSTRUCTIONS: # 7.00

TOTAL

DELIVERY MEMO - NOT AN INVOICE

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THE BLACK CAUCUS OF HEALTH WORKERS
OF
THE AMERICAN PUBLIC HEALTH ASSOCIATION
MEMBERSHIP CERTIFIED
FOR
William Small
FOR THE YEAR 1977
№ 624 [signature]
TREASURER

J & R ENTERPRISE
3705 Holt's Chapel Road
GREENSBORO, NORTH CAROLINA

PHONE 273-1422

JOHNNY McKOY
President

383-1551

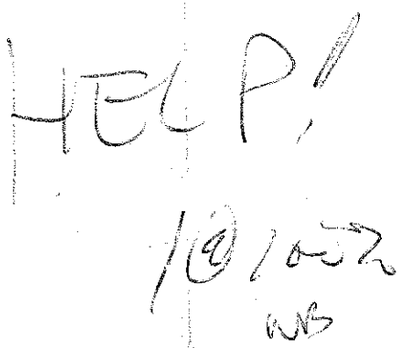
Holiday

15-501

Art # 20279

The Black Student Caucus and the Student Union Board of the School of Public Health of the University of North Carolina at Chapel Hill are presenting the first in what we hope will be a series of conferences focusing on the unique and special concerns of minority populations.

The theme of this year's conference is "Perspectives on the Health of Black Populations." We feel that the subject areas chosen for the focus of this conference are of special concern for public health professionals who will be working with black people. A further rationale in the selection of these areas is that we feel sufficient attention has not been given in the courses in the School of Public Health.



WEDNESDAY, MARCH 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Bernard G. Greenberg, Ph.D., Dean
Introduction of Program
Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker
Fred Levick, President, Student Union

Keynote Address
Health, Politics and Economics
Mr. Floyd McKissick, J.D.

10:00 a.m. Break

10:15 a.m. Panel Discussion - *Black Involvement in Health Policy*

Donald Ensley, Ph.D., Moderator

Public Health Practices and Minorities
William Montgomery, Ph.D.

"How the Federal government is addressing issues of equity in manpower"
Clay Simpson, Ph.D.

Black Manpower in the Health Field
E. Lavonia Allison, Ph.D.

12:30 p.m. Lunch

2:00 p.m. Panel Discussion
Institutional & Attitudinal Barriers in Health Care
Cynthia Jenkins, MSW, Moderator

The Impact of Racism
Audreye E. Johnson, D.S.W.

The Role of Folk Medicine
Ruth Dennis, Ph.D.

Blacks as Objects of Experimentation
William Darity, Ph.D.

4:45 p.m. Social Hour - Student Lounge, School of Public Health

THURSDAY, MARCH 31, 1977

Auditorium - Rosenau Hall

10:00 a.m. Panel Discussion:
Rural Health Perspectives
Robert Kelly, MPA, MPH, Moderator

Panelists:
John Hatch, Ph.D.

C. Arden Miller, M.D.

H. Jack Geiger, M.D.

12:00 p.m. Lunch

2:00 p.m. Panel Discussion:
International Health Perspectives
Jeanne Jones, MSW, Moderator

Nutritional Aspects
Joseph Edozien, M.D., Ph.D.

African Perspectives
Glenn Roane, Ph.D.

Jim Lea, Ph.D.

Conference Participants

E. Lavonia Allison
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

William Darity, Ph.D.
Dean
School of Public Health
University of Massachusetts at Amherst

Ruth Dennis, Ph.D.
Professor
Department of Psychiatry
Meharry Medical College

Joseph Edozien, M.D., Ph.D.
Chairman
Department of Nutrition
School of Public Health
University of North Carolina - Chapel Hill

Donald Ensley, Ph.D.
Associate Professor
Department of Community Health
East Cardera University

H. Jack Geiger, M.D.
Chairman and Professor
Department of Community Medicine
State University of N.Y. at Stony Brook

Bernard G. Greenberg, Ph.D.
Dean
School of Public Health
University of North Carolina - Chapel Hill

John Hatch, Ph.D.
Associate Professor
Department of Health Education
School of Public Health
University of North Carolina - Chapel Hill

Cynthia Jenkins
Ph.D. Candidate - Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

Audreye E. Johnson, D.S.W.
Associate Professor
School of Social Work
University of North Carolina - Chapel Hill

Jeanne Jones
Ph.D. Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Robert Kelly
Ph.D. Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Jim Lea, Ph.D.
Director
African Health Training Institutes Project
Carolina Population Center
University of North Carolina - Chapel Hill

Fred Levick
MPH Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Doris Magwood
MPH Candidate - Health Administration
School of Public Health
University of North Carolina - Chapel Hill

Floyd McKissick, J.D.
President, Soul City Company
Soul City, North Carolina

C. Arden Miller, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

William Montgomery, Ph.D.
Deputy Secretary for Health Systems Development
Pennsylvania Department of Health
Harrisburg, Pennsylvania

Glenn Roane, J.D.
Director
Equal Opportunities Program
Department of State
Washington, D.C.

Earl Siegel, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina - Chapel Hill

Clay Simpson, Ph.D.
Associate Administrator for Health Resources
Opportunity Programs
Health Resources Administration
Public Health Service
Department of Health, Education & Welfare

Sponsoring School
School of Public Health
University of North Carolina at Chapel Hill
Bernard G. Greenberg, Ph.D., Dean

Conference Planning Committee
Janet Miles
Derek Daugherty
Sherry Milan
Doris Magwood
Milton Gunn
Patricia Parker
Rosyland Frazier
William Small

Cover Design: James Neville

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill.

Perspectives On The Health Of Black Populations

March 30 and 31, 1977

FORUM

Perspectives On The Health Of Black Populations

March 30 and 31, 1977

Co-sponsored by the Black Student Caucus and the Student Union Board of the School Of Public Health Of the University of North Carolina at Chapel Hill

~~TENTATIVE PROGRAM~~

Wednesday, March 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Dr. Bernard G. Greenberg, Dean
Introduction of Program - Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker - Fred Levick, President
Student Union

Keynote Address
Mr. Floyd McKissick, J.D.
President, Soul City Company
Soul City, N.C.

10:00 a.m. Break

10:15 a.m. Panel Discussion - Black Involvement in Health Policy

_____ Moderator

Public Health Practices and Minorities - William Montgomery, Ph.D.
Deputy Secretary for Health Systems
Development, Pa. Dept. of Health

~~Issues of Equity in Manpower~~ - Clay Simpson, Ph.D.
"How Federal government is addressing issues of equity in manpower"
Associate Administrator for Health Resources
Opportunity Programs, Health Resources Admin.
Public Health Service, DHEW

Black Manpower in the Health Field - E. Lavonia Allison, Ph.D., Director
North Carolina Health Manpower Corp.

12:30 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - Institutional & Attitudinal Barriers In Health Care

_____ Moderator

The Impact of Racism - Audreye E. Johnson, D.S.W., Associate Professor
School of Soc. Work, Univ. of N.C.

The Role of Folk Medicine - Ruth Dennis, Ph.D., Professor
Dept. of Psychiatry, Meharry Medical College

Blacks as Objects of Experimentation - William Darity, Ph.D., Dean
School of Public Health
Univ. of Mass. at Amherst

4:45 p.m. Social Hour - Student Lounge, School of Public Health

Panelists: title

Audreye E. Johnson, D.S.W.

title

Ruth Deans Phd

title

William Darity Ph.D.

4:45 p.m. Social Hour

Student Lounge, School of Public Health

E. Lavonne Allison, Ph.D.
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

Cynthia Jenkins
Ph. D. candidate - Maternal and child health
SPH
UNC-CH

Audreye E. Johnson, D.S.W.
Associate Professor
School of Social Work
UNC-CH

Ruth Dennis, Ph. D
Professor
Department of Psychiatry
Meharry Medical College

William Darrity Ph.D
Dean
School of Public Health
University of Massachusetts at Amherst

Robert Kelly
Ph. D. candidate HADM
SPH
UNC-CH

John Hatch, Ph. D.
Associate Professor
Department of Health Education
School of Public Health
UNC-CH

Jim Leu, Ph.D.
Director
African Health Training Institutes Project
Carolina Population Center
UNC-CH

Earl Siegel, M.D.
Professor
Dept of MCH
SPH
UNC-CH

The Black Student Caucus and the Student Union Board of the School of Public Health of the University of North Carolina at Chapel Hill are presenting the first, in what we hope will be a series of conferences focusing on the unique and special concerns of minority populations.

The theme of this year's conference is "Perspectives on the Health of Black Populations". The subject areas chosen for the focus of this conference are ~~some which we feel~~ of special concern for public health professionals who will be working with Black people. A further rationale in the selection of these areas is that we feel sufficient attention has not been given in the courses in the School of Public Health to these concerns.

please list w/ addresses etc.

Conference Participants

Bernard G. Greenberg Ph.D
Dean
School of Public Health
University of North Carolina - Chapel Hill

Doris Magwood
MPH candidate - HADM
SPH - spell out
UNC - CH

Fred Leveck
MPH candidate
SPH
UNC - CH

Floyd McKissick, J.D.
President, Soul City Company
Soul City, North Caroline

William Montgomery, Ph.D.
Deputy Secretary for Health Systems Development
Pennsylvania Department of Health
Harrisburg, Pennsylvania

Clay Simpson, Ph.D
Associate Administrator for Health Resources Opportunity Programs
Health Resources Administration
Public Health Service
D.H.E.W.

Donald Ensley, Ph. D.
~~Ph.D. candidate - HADM~~
~~SPH~~
~~UNC - CH~~

C. Arden Miller, M.D.
Professor
Department of Maternal and Child Health
SPH
UNC - CH

H. Jack Geiger, M.D.
Chairmen and Professor
Department of Community Medicine
State Uni. of N.Y. at Stony Brook

Jeanne Jones
Ph.D. candidate - HADM
SPH
UNC - CH

Joseph Edozien M.D. Ph.D
Chairmen
Department of Nutrition
SPH
UNC - CH

Glenn Roane Ph.D.
Director
Equal Opportunities Program
Department of State
Washington, D.C.

Assign seat
Prep Comm reg
Easy reading

Thursday, March 31, 1977 - Auditorium Rosenau Hall

10:00 am - 12:00 pm Panel: Rural Health Perspectives
Moderator: Robert Kelly MPA, MPH
Panelists:
John Hatch, Ph.D
C. Arden Miller, M.D
H. Jack Geiger M.D.

12:00 a.m. - 2:00 p.m. Lunch

2:00 p.m - 4:30 p.m. Panel: International Health Perspectives
Moderator: Jeanne Jones MSW
Panelists:
Joseph Edozien, M.D. Ph.D.
Glenn Roane, Ph.D.
Jim Lea, Ph.D.
Earl Siegel, M.D.

4:30 - 5:00 Concluding Remarks

SPH
logo

Sponsoring School

School of Public Health

University of North Carolina at Chapel Hill

Bernard G. Greenberg, Ph. D., Dean

Conference Planning Committee

Janet Miles

Derek Daugherty

Sherry Milan

Doris Magwood

Milton Gunn

Patricia Parker

Rosyland Frazier

William Small

Cover design: James Neville

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill

Wednesday, March 30, 1977 - Auditorium Rosenau Hall

9:00 a.m. - 9:10 a.m. Welcoming Remarks
Bernard G. Greenberg, Ph.D
Dean

9:10 am - 9:20 a.m. Opening of the Conference
Dana Maywood, Chairperson
Black Student Caucus

9:20 am - 10:00 am. Introduction of Keynote Speaker
Fred Lewick, President
Student Union

Keynote Address
title
Mr. Floyd McKissick J.D.

10:00 am - 10:15 a.m. Break

10:15 am - 12:30 p.m. Panel: Black Involvement in Health Policy
Moderator: Donald Ensley Ph.D.
Panelists: title
William Montgomery, Ph.D
title
Clay Simpson, Ph.D
title
E. Lavinia Allison, Ph.D.

12:30 pm - 2:00 p.m. Lunch

2:00 pm - 4:15 p.m. Panel: Institutional and Attitudinal Barriers in Health Care
Moderator. Cynthia Jenkins MSW

~~TENTATIVE PROGRAM~~

Thursday, March 31, 1977 — 10 B A/C

Auditorium - Rosenau Hall — 10 B W

9:30 a.m. Panel Discussion - Rural Health Perspectives

_____ Moderator

Panelists - John Hatch, Ph.D., Associate Professor
Dept. of Health Education
School of Public Health, Univ. of N.C.

C. Arden Miller, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

H. Jack Geiger, M.D., Professor & Chairman
Dept. of Community Medicine
State University of New York at Stony Brook

12:30 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - International Health Perspectives

_____ Moderator

Nutritional Aspects - Joseph Edozien, M.D., Ph.D., Chairman
Dept. of Nutrition
School of Public Health, Univ. of N.C.

African Perspectives - Glenn Roane, Ph.D.
Former Director of Regional Population Office for Africa U.S. Agency for International Development
Washington, D.C.

Jim Lea, Ph.D., Director
African Health Training Institutes Project
Carolina Population Center, Univ. of N.C.

Carribean Perspectives - Earl Siegel, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

4:30 p.m. Adjourn

Conference Participants

E. Lavonia Allison
Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

William Darity, Ph. D.
Dean
School of Public Health
University of Massachusettes at Amherst

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Mehary Medical College

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Associate Professor
Dept. Comm. Health
East Cardera Uni.

H. Jack Geiger, M.D.
Chairman and Professor
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State University of N.Y. at Stony Brook

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School of Social Work
UNC-Ch

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SPH
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Robert Kelly
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Department of Health Education
School of Public Health
UNC-Ch

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Deputy Secretary for Health Systems Development
Pennsulvania Department of Health
Harrisburg., Pennsylvania

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SPH logo — to come in later

Sponsoring School

School of Public Health
University of North Carolina at Chapel Hill
Bernard G. Greenberg, Ph. D., Dean

Conference Planning Committee

Janet Miles
Derek Daugherty
Sherry Milan
Doris Magwood
Milton Gunn
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Rosyland Frazier
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Cover Design: James Neville

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill.

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Department of State
Washington, D.C.

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Department of MCH
SPH
UNC-Ch

Clay Simpson, Ph.D.
Associate Administrator for Health Resources Opportunity Programs
Health Resources Administration
Public Health Service
D.H.E.W.

March 23, 1977

Projected Budget for March 30 & 31 Conference

Travel for out-of-town presenters (standard roundtrip airfares quoted by Continental Travels)

New York, N.Y.	$114.00	
Harrisburg, Pa.	98.00	
Hartford, Conn.	136.00	
Nashville, Tenn.	126.00	
Washington, D.C.	80.00	
Cabs & Tips	60.00	6 @ $10.00
Total Travel	$608.00	---- $610.00

Lodging - Carolina Inn or Comparable facility

6 rooms	$100.00	@ $15.00 + taxes medium priced
Meals	90.00	@ 15.00
Total	$190.00	will give $30.00 for each participant

Coffee & Social Hour

Coffee and/coke for break	$30.00	← 3lbs. 8x3 = $24 coffee
Social Hour	30.00	
Relish tray & nuts	20.00	
Cups & napkins	20.00	
Total	100.00	

Advertisement & Miscellaneous

Posters	$15.00	
Handbills	35.00	
Mailing	20.00	(D.O.)
Program printing	70.00	
	$140.00	

Honorarium	$750.00	5 @ $150.00
Miscellaneous	200.00	
Total	1988.00	----------$2000.00

URBAN HEALTH
THE JOURNAL OF HEALTH CARE IN THE CITIES

March 7, 1977

Mr. William T. Small
Assistant Dean
The University of North Carolina
School of Public Health
Chapel Hill, N.C. 27514

Dear Mr. Small:

Thank you very much for the notice on the forthcoming conference on "Perspectives on the Health of Black Populations."

Because of some other travel commitments, it will not be possible for me to attend. However, we would like to have a news release following the conference, and a photo, to carry in the June issue of this journal. Perhaps a photo of the panel featuring Drs. Ensley, Montgomery, Simpson and Lavonia Allison.would be good if you plan to have a photographer at the event.

I hope that the meeting is successful.

Yours truly,

Harold Hamilton

Harold Hamilton
Publisher

URBAN PUBLICATIONS • P. O. BOX 42409 • ATLANTA, GEORGIA 30311 • (404) 344-7581

Conf

1124-3rd Street, S.W.
Washington, D.C. 20024
March 6, 1979

W. T. Small, Assistant Dean
School of Public Health
University of North Carolina
at Chapel Hill
Rosenau Hall 201 H
Chapel Hill, North Carolina 27514

Dear Mr. Small:

Thank you for your letter of February 7, 1979, concerning the third annual Minority Health Conference. I am sorry that I was not able to attend the conference. I am interested in the School of Public Health at the University of North Carolina and thus there are a number of questions that are unanswered.

I looked through the bulletin which you sent me and found a program that I am particularly interested in. This program being that of Maternal and Child Health. I understand that one needs two-years of experience in that area before they can be admitted. I am interested in this field but I don't have the experience because I just recently graduated in September 1978. Do you have a program in General Public Health where I can gain academic experience in this area without having this experience.

Any assistance that you are able to provide will be greatly appreciated.

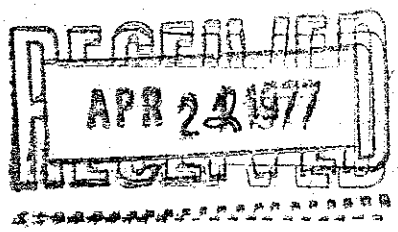
Very truly yours,

Lisa L. Zackery
(202) 484-0495

North Carolina Health Manpower Development Program
Room 201, NCNB Plaza
136 East Rosemary Street - 322A
Chapel Hill, N.C. 27514

Dr. E. Lavonia Allison
Director

Phones: (919) 966-2264
(919) 966-2265



April 20, 1977

Mr. William T. Small
Assistant Dean
School of Public Health
140 Rosenau Hall, 201H
CAROLINA CAMPUS

Dear Bill:

This is to acknowledge receipt of your letter of April 14, 1977. It was surely my pleasure to have the opportunity to serve as a panelist during the recent conference, "Perspectives on the Health of Black Populations".

A formal manuscript was not used for my presentation; however, enclosed is a copy of an Overview of NCHMDP from which major parts of my presentation were taken. Also enclosed are copies of the transparencies that made up the visual parts of my presentation. Hopefully the materials provided will be helpful in the compilation of the proceedings as related to my presentation.

I look forward to receiving a copy of the proceedings.

Very sincerely yours,

Lavonia

E. Lavonia Allison
Director

mr

Enclosures - Overview of NCHMDP
Statistical Data of Presentation

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

O V E R V I E W

The North Carolina Health Manpower Development Program (NCHMDP) was organized in 1971 as a consortium of educational institutins and community health services agencies to address the state's shortage of health manpower -- especially in minority and disadvantaged communities. In 1974, NCHMDP became an inter-institutional program of the University of North Carolina System, operating under the aegis of UNC-Chapel Hill and responsible to the Vice Chancellor for Health Affairs.

NCHMDP consists of a Central Office in Chapel Hill; three regional centers at North Carolina Central University, Elizabeth City State University, and Pembroke State University; and a 32-member Health Manpower Advisory Council with representatives from educational institutions, public and private health agencies and societies, health employers, and community health consumers.

North Carolina is presently far behind the national average in almost every category of health manpower. Nationally, there is one physician for every 775 persons while North Carolina has only one physician for every 1,020 persons. In optometry, there is one practitioner for every 10,554 persons nationally. In North Carolina that ratio is 1:15,241. The nation has a ratio of 1:28,541 in podiatry while North Carolina's ratio is 1:213,375. The trend continues, unfortunately, in the allied health professions where the state's ratio of practitioners to population is consistently higher than the national ratio.

For the state's minorities and disadvantaged, the figures are even worse. While the national ratio of minority physicians to the minority

population is 1:3,824, North Carolina records a ratio almost twice as high -- 1:7,375. In optometry, the minority ratio is 1:228,901 for the nation and 1:293,147 for the state. The most telling statistic is in podiatry where there is no minority representation in the state. Statistics on other health professions are presented in Fact Sheet #1.

The figures for minority health manpower in the state are even more revealing when one considers the fact that North Carolina has the sixth largest black population in the nation and is the home of more predominantly minority four-year institutions (11) than any other state in the U.S. These 11 institutions enroll approximately 21,000 students and when combined with minority students enrolled in the state's other public and private 48 institutions it constitutes a formidable resource within the state. Also deserving mention is the state's American Indian population, which is the fifth highest of any state, whose representation in the health professions is practically nil.

The reasons for the serious underrepresentation of minorities in all seven health disciplines (MODVOPP) as well as in the other professional areas such as nursing, public health, and allied health are both complex and varied. Many minority students in North Carolina have not been afforded an equality of educational opportunity that would enhance their competitiveness in the admission/selection process to undergraduate health training programs and to health professional schools. They have also had limited exposure to a broad range of role-models representing the many health career opportunities for which training is available in North Carolina and in other programs not offered in North Carolina, such as optometry, podiatry, osteopathy, and veterinary medicine. Complicating the problem is the impression that health training and professional programs require a lengthy and costly educational

process. There is also the lack of awareness on the part of many minority students that health careers are available in a broad range of fields requiring as little as one year post-secondary training to as many as 12-15 years training (M.D. specialty).

To address this problem, NCHMDP has a multi-purpose program designed to: (1) increase the number of minority and disadvantaged persons being trained and employed in health careers; (2) increase the availability of health services to minority and disadvantaged communities; (3) increase the commitment on the part of all service agencies on behalf of improved health care to minority and disadvantaged communities; (4) improve the quality of health care delivery and services for minority and disadvantaged persons.

To accomplish its goals, NCHMDP provides: general informatin on more than 200 health careers and specific information on health training programs in North Carolina and other states; health career counseling on prerequisites for admission, standardized tests required, and procedures for applying to health training programs; assistance to students applying to health training programs, an advocate service for their admission, and referrals when needed; information about appropriate sources of financial assistance for students in health training programs; academic skills development materials and health sciences self-instructional programs to guidance counselors, health occupations teachers, and health science faculty members at post-secondary institutions; a health career film loan service; and a Clinical Work-Study Summer Health Program that offers clinical and academic enrichment experiences for minority and disadvantaged college students enrolled in a health or health-related curriculum.

NCHMDP also publishes a quarterly newsletter, ACTION, which is distributed to approximately 4,000 individuals, agencies, and societies, including counselors at all of the state's junior and senior high schools and pre-professional counselors in the 16 Institutions Health Sciences Consortium; distributes a directory of pre-medical and pre-dental summer academic enrichment programs to pre-professional advisors and minority students; offers an employment referral service for minority health professionals; maintains a working directory on more than 200 health training programs; and sponsors workshops for health science faculty members from the predominantly minority institutions in the 16 Institutions Health Sciences Consortium, for the purpose of introducing faculty members to methods for improving students' skills and abilities in the basic sciences required as prerequisites for admission to health professional programs.

During 1975-76, NCHMDP activities showed marked increases, especially

North Carolina Health Manpower Development Program

"Increasing minority health manpower"

GOALS

1. To increase the number of minority persons trained and employed in health careers
2. To increase the availability and improve the quality of health care in minority communities
3. To increase official commitment to improvement of health services for minority people

ACTIVITIES

STATEWIDE INFORMATION AND COMMUNICATION NETWORK

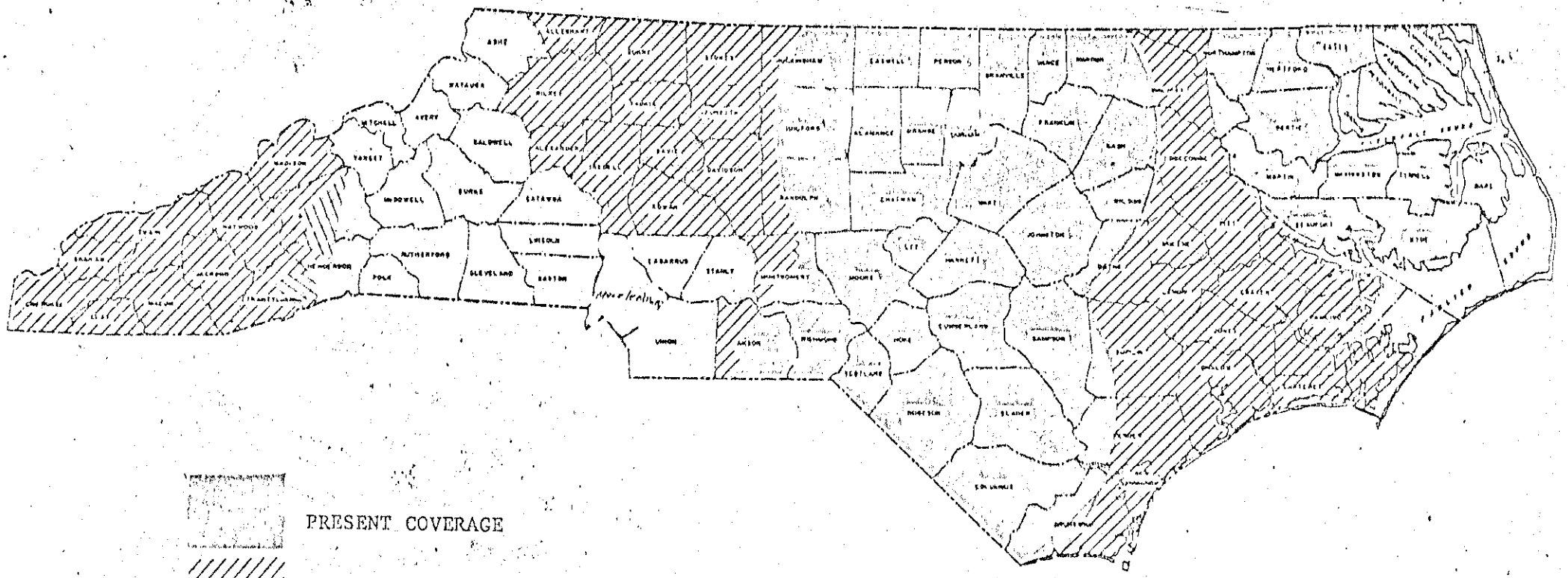
General
Specific health careers
T.I.
UG.
Grad.
Prof.

ACTION newsletter
Workshops
CWSSHP
Counseling
Community assistance NHSC

NCHMD
central office
regional centers
psu
nccu
unc
ecsu
SC
GA
TENN
VA

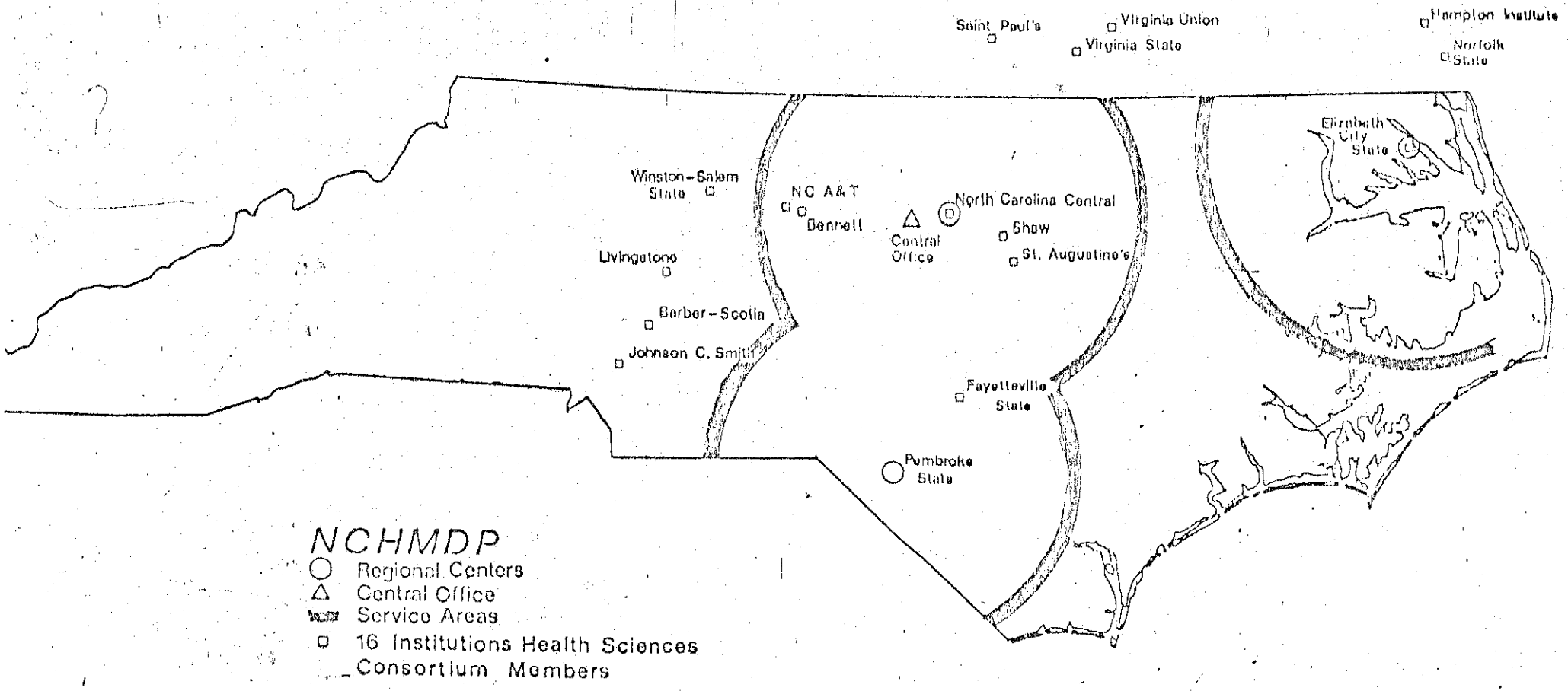
NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

GEOGRAPHIC REGIONS OF NCHMDP HEALTH CAREERS RECRUITMENT, COUNSELING, AND RETENTION SERVICES



PRESENT COVERAGE

PROPOSED EXTENDED COVERAGE


Saint Paul's
Virginia Union
Virginia State
Hampton Institute
Norfolk State
Elizabeth City State
Winston-Salem State
NC A&T
Bennett
Central Office
North Carolina Central
Shaw
St. Augustine's
Livingstone
Barber-Scotia
Johnson C. Smith
Fayetteville State
Pembroke State
NCHMDP
Regional Centers
Central Office
Service Areas
16 Institutions Health Sciences
Consortium Members

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

	Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employed
PHYSICIANS:							
U.S.	**291,222	6,106	2%	1:775	1:3,824	1:673	1:47
N.C.	5,039	159	3%	1:1,020	1:7,375	1:861	1:32
DENTISTS:							
U.S.	91,025	2,098	2%	1:2,380	1:11,129	1:2,038	1:43
N.C.	1,421	58	4%	1:3,655	1:20,217	1:2,998	1:26
OPTOMETRISTS:							
U.S.	19,254	102	.5%	1:10,554	1:228,901	1:9,549	1:188
N.C.	336	4	1%	1:15,241	1:293,147	1:12,031	1:84
PHARMACISTS:							
U.S.	109,642	2,501	2%	1:1,853	1:9,335	1:1,662	1:44
N.C.	2,043	64	3%	1:2,506	1:18,322	1:2,018	1:32
PODIATRISTS:							
1/U.S.	7,120	223	3%	1:28,541	1:104,699	1:25,823	1:32
2/N.C.	24	-0-	0%	1:213,375	0:1,172,589	1:166,438	0:24
3/**R.N.'s:**							
U.S.	829,691	62,335	8%	1:245	1:375	1:232	1:13
N.C.	17,565	1,886	11%	1:292	1:622	1:255	1:9
VETERINARIANS:							
U.S.	19,435	252	1%	1:10,456	1:92,651	1:9,284	1:77
N.C.	315	6	2%	1:16,357	1:195,432	1:12,927	1:53

* Blacks and Native Americans only

** All figures, except where noted, from Minorities & Women in the Health Fields, DHEW, September 1975

1/ Figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

2/ Figures from National Podiatry Association Newsletter, Vol. 3, February 1976

3/ Includes graduates of all R.N. programs

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

	Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employed
DIETITIANS:							
U.S. **	40,225	7,469	19%	1:5,052	1:3,126	1:5,420	1:5
N.C. ***	1,251	351	28%	1:4,094	1:3,340	1:4,438	1:4
CLINICAL LAB.:							
U.S.	118,264	11,179	9%	1:1,718	1:2,089	1:1,661	1:11
N.C.	2,156	287	13%	1:2,375	1:4,085	1:2,150	1:8
DENTAL HYG.:							
U.S.	17,458	301	2%	1:11,640	1:77,568	1:10,381	1:58
N.C.	238	-0-	0%	1:21,517	0:1,172,589	1:16,784	0:238
DENTAL ASST.:							
U.S.	90,497	3,337	4%	1:2,246	1:6,997	1:2,043	1:27
N.C.	1,740	79	5%	1:2,943	1:14,843	1:2,405	1:22
DENTAL LAB. TECH.:							
U.S.	26,810	1,476	6%	1:7,580	1:15,818	1:7,030	1:18
N.C.	322	33	10%	1:15,904	1:35,533	1:13,822	1:10
HEALTH ADM.:							
U.S.	84,461	4,166	5%	1:2,405	1:5,604	1:2,218	1:20
N.C.	1,879	168	9%	1:2,725	1:6,980	1:2,335	1:11
HEALTH REC.:							
U.S.	10,946	547	5%	1:18,565	1:42,684	1:17,127	1:20
N.C.	199	9	5%	1:25,734	1:130,286	1:20,073	1:22

* Blacks and Native Americans only

** U.S. figures from Minorities and Women in the Health Fields, DHEW, September 1975

*** N.C. figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

NORTH CAROLINA HEALTH MANPOWER DEVELOPMENT PROGRAM

FACT SHEET #1

		Total	Minority*	% Min.	Tot./Tot. Pop.	Min./Min. Pop.	White/White Pop.	Min./Tot. Employ
LAY MIDWIVES:								
U.S.	**	941	375	40%	1:215,954	1:62,261	1:314,677	1:3
N.C.	***	36	30	83%	1:142,250	1:39,086	1:665,750	1:1
NURSING AIDES, ORDERLIES, ATTND.:								
U.S.		723,576	187,523	26%	1:281	1:125	1:332	1:4
N.C.		14,356	6,118	43%	1:357	1:192	1:485	1:2
PRACT. NURSES:								
U.S.		235,546	52,306	22%	1:863	1:446	1:972	1:5
N.C.		4,218	1,181	28%	1:1,214	1:993	1:1,315	1:4
OPTICIANS, LENS GRINDERS, POLISH.:								
U.S.		27,844	1,215	4%	1:7,298	1:19,216	1:6,688	1:23
N.C.		367	14	4%	1:13,954	1:83,756	1:11,316	1:26
RADIOLOGIC:								
U.S.		52,566	3,676	7%	1:3,866	1:6,351	1:3,643	1:14
N.C.		893	80	9%	1:5,734	1:14,657	1:4,913	1:11

* Blacks and Native Americans only
** U.S. figures from Minorities and Women in the Health Fields, DHEW, September 1975
*** N.C. figures from Barriers to Minorities in Allied Health Professions Education, DHEW, August 1975

MINORITY ENROLLMENT, UNC-CHAPEL HILL, HEALTH AFFAIRS, FALL 1976 NCHMOP

SCHOOL	TOTAL ENROLLMENT	BLACK / %	AMERICAN INDIAN / %	TOTAL MINORITY ENROLLMENT /
MEDICINE	560	77 / 13.8%	12 / 2.1%	89 / 15.9%
DENTISTRY	328	13 / 3.9%	4 / 1.2%	17 / 5.2%
PHARMACY	582	22 / 3.8%	1 / .12%	23 / 3.9%
PUBLIC HEALTH	512	50 / 9.8%	4 / .78%	54 / 10.5%
MED. TECH.	24	2 / 8.3%	0 / 0.0%	2 / 8.3%
PHYS. THERAPY	48	3 / 6.2%	1 / 2.0%	4 / 8.3%
RADIOLOGY	3	1 / 33.3%	0 / 0.0%	1 / 33.3%
DENTAL HYGIENE	139	2 / 1.4%	0 / 0.0%	2 / 1.4%
NURSING	292	15 / 5.1%	2 / .68%	17 / 5.8%
TOTALS	2,448	185 / 7.6%	24 / .98%	209 / 8.5%

HEADCOUNT ENROLLMENT AND GRADUATES UNC-CH 1975-76

FACT SHEET #3

SCHOOLS	SIZE OF ENTERING CLASS	BLACK			AMERICAN INDIAN			TOTAL MINORITY ENROLLMENT			ALL OTHER			TOTAL ENROLLMENT			GRADUATES			MINORITY GRADUATES							
																				BLACKS			INDIANS			TOTAL	
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
TISTRY)	83 (83)	8	2	10	1	1	2	9	3	12	285	29	314	294	32	326	78	2	80	0	0	0	0	0	0	0	0
CINE	140 (160)	48	23	71	6	2	8	54	25	79	359	85	444	413	110	523	96	27	123	8	6	14	0	0	0	9	5
IC HEALTH	217 (280)	26	27	53	4	1	5	30	28	58	264	240	504	294	868	662	125	112	237	7	11	18	2	0	2	9	11
MACY dergrad.)	159 (160)	11	10	21	2	1	3	13	11	24	294	276	570	307	287	594	80	63	143	3	1	4	1	0	1	4	1
MACY ad.)		0	0	0	0	0	0	0	0	0	10	6	16	10	6	16	5	6	11	0	0	0	0	0	0	0	0
ICAL HNOLOGY	(24)	0	1	1	0	0	0	0	1	1	2	21	23	2	22	24	2	22	24	0	1	1	0	0	0	0	1
SICAL RAPY	(24)	0	3	3	0	0	0	0	3	3	7	36	43	7	39	46	4	18	22	0	2	2	0	0	0	0	2
ICLOGIC ENCE	5 (12)	1	0	1	0	0	0	1	0	1	0	4	4	1	4	5	0	0	0	0	0	0	0	0	0	0	0
IOLOGIC HNOLOGY	Term, Cert, Prog.	0	0	0	0	0	0	0	0	0	2	5	7	2	5	7	2	5	7	0	0	0	0	0	0	0	0
TAL HYGIENE dergrad, Cert,)	(50)	0	1	1	0	0	0	0	1	1	0	113	113	0	114	114	0	62	62	0	0	0	0	0	0	0	0
..T.E.	(10)	0	0	0	0	0	0	0	0	0	1	22	23	1	22	23	0	9	9	0	0	0	0	0	0	0	0
TAL LISTING	(60)	1	4	5	0	0	0	1	4	5	0	48	48	1	52	53	1	50	51	1	3	4	0	0	0	1	1
SING dergrad.)	(150)	0	16	16	0	0	0	0	16	16	13	267	280	13	283	296	4	127	131	0	10	10	0	0	0	0	1

MEDICAL SCHOOL ENROLLMENT — SELECTED YEARS

NCHMDP

FIRST YEAR CLASS

UNITED STATES	Total	Black	%	NORTH CAROLINA	Total	Black	%
1974-75	14,763	1,106	7.5	1974-75	343	39	11.4
1975-76	15,295	1,036	6.8	1975-76	360	41	11.0

TOTAL ENROLLMENT

UNITED STATES	Total	Black	%	NORTH CAROLINA	Total	Black	%
1974-75	53,554	3,355	6.3	1974-75	1,303	103	7.9
1975-76	55,818	3,456	6.2	1975-76	1,377	119	8.6

MEDICAL SCHOOL ENROLLMENT — N. C. SCHOOLS

Bowman Gray (BG) Duke (DU) UNC - Chapel Hill (UNC)

FIRST YEAR CLASS

	Total	Black	%		Total	Black	%
1974-75	90 (BG)	8	8.8	1975-76	101 (BG)	7	6.9
	122 (DU)	10	8.2		119 (DU)	12	10.0
	131 (UNC)	21	15.7		140 (UNC)	22	15.7
	343	39	11.0		360	41	11.0

TOTAL ENROLLMENT

	Total	Black	%		Total	Black	%
1974-75	347 (BG)	20	5.7	1975-76	369 (BG)	19	5.1
	462 (DU)	27	5.9		485 (DU)	31	6.4
	494 (UNC)	56	11.4		523 (UNC)	69	13.2
	1,303	103	7.9		1,377	119	8.6

DENTAL SCHOOL ENROLLMENT, 1976-1977

UNITED STATES

YEAR	TOTAL	BLACK	% OF BLACK ENROLLMENT
1ST	5,935	291	4.9
2ND	5,616	237	4.2
3RD	4,235	220	5.1
4TH	5,227	207	3.9
	21,013	955	4.5

NORTH CAROLINA

YEAR	TOTAL	BLACK	% OF BLACK ENROLLMENT
1ST	84	3	3.6
2ND	82	4	4.8
3RD	81	4	4.8
4TH	78	2	2.6
	325	13	4.0

DENTAL SCHOOL GRADUATES, 1976

UNITED STATES

TOTAL	BLACK	% OF BLACK GRADUATES
5;336	213	3.9

NORTH CAROLINA

TOTAL	BLACK	% OF BLACK GRADUATES
80	0	0.0

Black Health Forum Held at The University of North Carolina

"Perspectives on the Health of Black Populations" was the theme of a two-day forum held at the University of North Carolina at Chapel Hill Wednesday and Thursday, March 30-31, 1977. The event was sponsored by the black student caucus and the student union board of the UNC School of Public Health. The keynote address was delivered by attorney Floyd McKissick, president of Soul City Company, who discussed the intricacies of "Health, Politics and Economics."

Various aspects of the health of black populations were explored in four panel discussions; (1) Black Involvement in Health Policy, (2) Institutional and Attitudinal Barriers in Health Care, (3) Rural, Health Perspectives, and (4) International Health Perspectives. Topics included "Public Health Practices", "How the Federal Government is Addressing Issues of Equity in Manpower", "Black Manpower in the Health Field", "The Impact of Racism", "Blacks As Objects of Experimentation" and "The Role of Folk Medicine".

Faculty from UNC participating included Drs. John Hatch, C. Arden Miller, E. Lavonia Allison, Joseph Edozien, James Lea, Earl Siegel and Audreye Johnson.

Visiting panelists included William Darity, dean, School of Health Sciences, University of Massschusetts, Ruth Dennis, professor of psychiatry, Meharry Medical College, H. Jack Geiger, chairman and professor of community medicine, State University at Stony Brook, William Montgomery, deputy secretary of health systems development, Pennsylvania Department of Health, Harrisburg, Pennsylvania, Glenwood Roane, director, equal opportunities program, Department of State, Washington, D. C. and Clay Simpson, associate administrator for health resources opportunity programs, Department of Health, Education, and Welfare, Washington, D. C.

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

27514

SCHOOL OF PUBLIC HEALTH
OFFICE OF THE DEAN

TELEPHONE
AREA 919, 966-1113

April 13, 1977

C. Arden Miller, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina
Chapel Hill, North Carolina 27514

Dear Dr. Miller:

On behalf of the faculty, student body and staff of the School of Public Health, I want to take this opportunity to thank you for serving as a panelist during our recent forum entitled "Perspectives On the Health of Black Populations". Those of us in attendance were delighted and inspired with your obvious expertise in your designated subject area and the outstanding manner in which you handled questions from the audience.

Since all sessions were recorded, I am hopeful that a compilation of the proceedings will be possible for public distribution in the near future. If you have a copy of your presentation, I will be most grateful if you will share it with me. If a formal presentation is not handy, we will transcribe your presentation from the tapes and forward a copy to you for editing prior to releasing it publicly.

Again, thank you for your support in making the forum a success.

Sincerely,

Bill

William T. Small
Assistant Dean

WTS:bb

Bill - I spoke from notes, which I have discarded.

Arden

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

27514

SCHOOL OF PUBLIC HEALTH
OFFICE OF THE DEAN

TELEPHONE
AREA 919, 966-1113

April 14, 1977

Earl Siegel, M.D.
Professor
Department of Maternal and Child Health
School of Public Health
University of North Carolina
Chapel Hill, North Carolina 27514

Dear Dr. Siegel:

On behalf of the faculty, student body and staff of the School of Public Health, I want to take this opportunity to thank you for serving as a panelist during our recent forum entitled "Perspectives On the Health of Black Populations". Those of us in attendance were delighted and inspired with your obvious expertise in your designated subject area and the outstanding manner in which you handled questions from the audience.

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Again, thank you for your support in making the forum a success.

Sincerely,

Bill

William T. Small
Assistant Dean

WTS:bb

4/15

Dear Bill

Thanks for your kind comments. Unfortunately, I don't have a copy of my informal remarks but I'd be pleased to edit the transcription.

Congrats to you & the students for the "super" forum!

Earl

APR 15 RECD

Arden Miller

It seems to be that an awful lot of smart people have been grabbing knapsacks and jumping over the issues of World Health Services and we act as if delivering adequate health services to people in world areas is really such a difficult issue that we don't know how to do it and I don't believe that. I think we do know how to do it and I think we have done it over and over again. Not to everyone who deserves that kind of care and attention but in demonstration projects that have been selectively successful. And I think whats wrong about our professing that is we don't know how to do it or that it is such a difficult thing to do is that as a group of people we have not yet made a commitment to do it. I think this relates to maybe bigger social issues. I think that as a society we really continue to behave as if people are not very important. Properties are important, privileges are important, but people are not very important to us. We continue to avoid rendering services known to be essential in ways that we know how to render, because it is part of our still kind of unstated policy, that is in some ways easier and more economical to abuse people than it is to serve them. Some people is easier to abuse than others. I think it is easier to abuse minority people, it is easier to abuse people who live in rural areas, it is easier to abuse poor people, but in truth is people who do not have a very high value in our society and I despair a little of substantial corrections until we can change that value. If one looks at some of the efforts that have been made to improve health services, it seems to me that three or four issues deserve attention; 1) an awful lot of attention has been given to assets to care in the belief that if we have the right kind of facility or the right kind of manpower in the right place the services will emerge and people will be taken care of. I want to come back and speak to that later. I think that has been the prevailing view of how to approach the problem. Considerable attention has been focused on how to alleviate the poverty at least in ways that provide increase purchasing power to poor people for services and this has been part of the Title V program, part of the Medicaid program, but there is reason to believe that though abundant justifications can be made for direct approach on problems of poverty an increase in people purchasing power doing this selectively

for medical care and medical services has not been as successful as we need to suggest. I think that there has yet been anyone who has suggested that what we need is not only ncreasing purchasing power, and not increase assets to services but some sense of increase public responsibility to render services, we do not have that and I think until we do not have that sense of public responsibility to reach people with essential services that we will continue to be grabbing at knapsacks and complaining that we don't really know how to solve the problem. What have been some of the past emphasis and some of thepast efforts to improve services to rural areas? Probably the oldest and the most conspicious is the one in which we had greatest experience was the Hill Buton program that was designed to build the 50 bed hospital with every county seat and be very nearly succeed in doing that. We have small hospitals scattered particularly throughout the south and midwest to such an extent that now the the Academy of Sciences issues a report that there ought to be a prohibition on building more hospital beds, we don't need more and the evidence is pretty good but not only do we not need more but the number we have made have the . Since they are terribly expensive to operate and they don't necessarily address themselves to the most critical health problems, but the most important of all even the existence of the hospital and the beds will not necessarily attract the kind of manpower and the kind of services that the people thought were essential. And even so, I don't know of any kind of effort better than that Hill Burton Program of possible of construction. that has more illustrations how you can put facilities in place and they still will not necessarily serve the people who are most in need. I know for example of the hospital in Mississippi is now involved in publication because of poor woman in labor came to that hospital emergency room seeking admission for the delivery of her baby and she was refusted admission on the basis that she had not received her prenatal care there. The up shot of that was that she delivered in the parking lot beside the hospital. Well with public funds we had put a facility in place, services were not improved. I knnow of a county in North Carolina where there are facilities and services established with public funds and with manpower present and in that county during 1975 there were better than 100 home deliveries by granny mid-wives. The reason that was given

by these people is that they really are refused service in the medical facilities unless they can provide prior evidence of capacity to pay the bills. We put manpower, we put facilities in place, we have not put in place commitments and until we do I think that we can spend an awful lot of money in retrogressive and nonproductive ways. Not only have we given lots of emphases on putting facilities and then attempting to improve assets, another major effort of the past decade or two has been the regionalization of services. We first did this around regionalized medical programs that was supposed to provide referral leakages that would reach out in satellite fashion initially around heart, cancer and stroke but many dread diseases and provide referral and flow patterns for people to get in and take advantage of the most sophisticated kinds of health services. We are doing the same thing now around regionalized prenatal care. Supposedly, we could establish referral networks in primary and secondary ternary hospitals so everybody gets referred according to their greatest needs. I hope that workds but I must confess grave misgivings about it because so far our experience with such regionalized programs of care is to the money flows to the most elaborate technological center. But the services patterns don't get developed from the outreach patterns though and people don't flow into those programs at the primary and community levels. Again, there has been more of a commitment in that regionalized experience to elaborate technological centers than there has been a commitment actually to reach people with essential services. Our experience with efforts to improve services on behalf of people, particularly rural and poor people with payment mechanisms is expecially fascinating again economical theory was that if people in sparsely served areas have purchasing power through medicaid if that purchasing power would attract Doctors with attract services and we would attempt to correct the problem of maldistribution in that way and it not only has not worked but all the evidence I see indicates that since an enactment entitles 18 or 19 and maldistribution positions for example has worrisome they create their demands and its more comfortable for them to create that demand in surburban centers that it is rural areas in such reimbursement programs if any thing had worsened rather than improved access to servicing in rural areas at least a reflected by physican manpower distribution. We have had a substantial background and substantial

experience with attempting to improve services in rural areas through educational emphasis and we are doing that now through the AHEC programs, we did it during the 1950's and 60's with the programs of rural preceptorships that were fashionable in many medical schools and I had fairly extensive experience with a mid-western medical school that required all of its senior medical students to spend six weeks to three months in service with a general practitioner in a small town in the western part of the state. The belief being that if continuing education were offered those people with consultation and support and encouragement and mostly if you educated them to the kind of primary medical care that needed to be rendered in those small towns that they would settle there rather than in suburban areas and after ten years I think the most sincere conscientious, intensive experience that could have been mounted it was found in that medical school that just as amny of its graduates was practicing orthomology in California as was true in any other school. But what has influenced where doctors go is not that kind of an educational emphasis but economic poles they go into areas of economic growth rather or not our AHEC program will reverse that. I think it is premature to tell it shaome advantages and if the AHEC centers tend to be located also in areas where there are economic poles and economic growth then I suspect that there are bankers and lawyers and all kinds of people increasing in numbers in those areas and not just positions whether it will improve services to people in the most sparsely populated areas we don't know. What are some programs that really do work? I am reminded of a number of years ago one of my first contacts in North Carolina with a fascinating experience in an eastern county of the state during a kind of survey for us. As a part of that survey we went to a little local county hospital in reviewing the nature of services there and I became concerned in meeting with the director of the hospital and reviewing the recently submitted annual report of the services of that hospital provided that one-third of all the major surgery that hospital was performing was surgery that was for sterilization. They were doing a tremendous number of hysterectomies and self injuectomies and their clinentele for the most part was largely the white middle-class clientele for that county. On the same visit down the road and across the stree, I visited the clinics of the local health department; they serve predominantly the poor people and the black population and the

afternoon I was there they were offering a family planning clinic and it was a superb clinic. It was well staffed and they were dispensing at no cost either a intrauterus device pills to large numbers of women. They were getting better care than the middle-calss women at the hospital who are having their uteruses removed and I fight that to give emphasis to an idea that I want to develop more in the closing minutes of what I have to say and that is that we work in this country. I think that a prevailing health medical care clinic the programs for poor people are always poor programs and we have to avoid putting in place special programs for poor people because they will deteriorate and those poeple will not be well served and what poor people really deserve are the same kind of programs that I feel comfortable in and I don't believe that. It seems to me that the evidence of the past decade is pretty strong that those programs, the comprehensive neighborhood health center of OEO, the maternal and infant care, projects Title V, The Children and Youth Projects of Title V predominantly are programs designed selectively to serve poor populations often rural populations but not always sometimes isolated populations in inner cities and they have been superb most of the major accomplishments of the past decade in term of innovated uses of manpower, in terms of improved services, I think have orginated, not from the county hospital but from those demonstration projects designed primarily for poor people. We have not expanded them, we have not extended them to everyone who would benefit for many reasons but I think in part is the reason that I site in rather pious ways we insist that any kind of selective emphasis on behalf of poor people is retrogressive and does not serve their interest. I think that is a pious way to preserve privilege in the status quo. Now in temrs of the major recent study that I know about innovations that have been successful I think we should all pay attention and perhaps many of you attended the conference in Nashville where Ray Marshall and Karen D'vis and others reported their work. One of the best as far as I was concerned was karen Davis' report on this and its one of the best because I admire Karen so and I admire her for one reason because she's willing to change her mind and she's persuaded by evidence. I had served on the health advisory group for that study and know that at the time that Karen Davis went into it she went into it with a very strong

bias against the concept of the Comprehensive Health Center as a device for meeting health service needs, feeling that it was much too extravagant. She reports in this study that she looked at the rural primary health centers a number in which we have in North Carolina and others in Georgia. She looked at the group health practices many of them having established satelites and rural areas of the Trophic Clinic in Medicine Field, Kentucky as an example. She looked at the efforts of the National Health Service core finding that about only 13% of those men and women who were placed in rural areas to be of service ever really returned to those areas once their period of service is completed and further side of the interesting paradox that even though they are located there in the public offices there are sometimes in practice patterns where the poor people in the area can't afford their services and she sighted one instance in which the health service core physicians are largely under utilized but in their spare time they go over and work in the clinic at the county health department and the poor people go there and receive their care from the same physicians from whom they don't attend in the other clinics but most importnat of all Dr. Davis looked at the twenty or so comprehensive neighborhood health centers in the south and concluded that they rendered excellent care economically. The cost per patienet per care enrolled in thos ecenters amounted to about $200 per person per year which is no more and probably less than the counterpart care in more piecely ways in conventional voluntary systems. I conclude all of this by feeling strongyly that there needs to a national commitment to reach anybody who had by passed by our conventional more and delivery that we do know models of service that will reach people and that we need public commitment to do it. I think that public commitment could be done through a guideline that is written with our new health planning authority. I see no reason why each HSA should not be mandated to plan comprehensive health services for any popultion not adequately reached with immunization and prenatal care of the other structure of services we know they need before they plan from cap scanners and more elaborate technological advances and more hospital beds it seems to me that under Title V where every state that is required now to maintain at least one of the special projects that was initiated as see andline MIC projects. That it would be equally as easy to require

that those states not have just one but have such a special prject for any population group that can be demonstrated and be bypassed by conventional and delivery systems. I believer that kind of compulsory. A service commitment is necessary because I think it is impossible with private and volunatry mechanisms to reach neglected people our system will not do it.

Dr. Siegel's

Speech

I have had the opportunity over the last couple of years to spend some intensive periods in the Caribbean but in a very limited part of the Carribean, namely, Jamaica. Jamaica is the larges of the Caribbean Islands and probably is relatively influential. A very fine university is set in Jamaica, University of the West Indies. Whether there is an outstanding department of Social and Preventive Medicine (PLEASE INSERT MISSING WORDS OR WORD) as a public health person and a little bit of what I am going to share with you regarding the happenings in Jamaica very much emnates from professional standards activites and members of his staff. Institutes for nutrition for the Caribbean is located in the University of West Indies. So what I will try to do is tell you a bit about whats happening in Jamaica and things are happening very very fast in Jamaica. Anybody who is at all in tune with what is happening in that island knows that it is happening very fast. A bit of it was in Newsweek a month or so ago and displayed very well the social change that is taking place, the political change that is taking place in Jamaica. So if we could have the first slide, I will try to tell you a little bit about the history, a little bit about the geography, a bit about the culture. Jamaica is very much influenced by the U. S. because its only about 600 or 700 miles from the tip of Florida. It also is being influenced more and more in the last year or so by proximity to Cuba. It is an island, a beautiful island as most of the Caribbean islands are. The capitol, Kingston, has 500,000 people. A total of 2 million population. The rural population is about 50% of the Caribbean and I was hoping to be able to show you a bit about the geography and the terrain of Jamaica. The coastal areas are flat their are flat for 30 or 40 or 50 miles inland and those are the represents

of beach areas and the arid agriculture areas. The remainder of the island tends to be very rugged and farming is very difficult on those hillsides. Up in the upper right corner you see in the left floor corner of that inset the island of Jamaica you see Cuba just to its north very close and as I said now being quite influential in the development of Jamaica and Haiti and the Dominican Republic of being immediately east of Jamaica in the Caribbean. Jamaica received its independence from the British Isles in 1963. The two political parties are both labor parties, the Jamaica Labor and the Peoples National Party. The first presidentof Jamaica was Alexander Burstmonti. Burstmonti was the head of the Jamaica Labor Party which now finds itself the more conservative of the two parties. The Peoples National Party was headed by Norman Manly, whose son, Michael Manly, is the current Prime Minister and he was re-elected for a period of 5 years. That party has been since its selection 5 years previously very strongly committed two social change and an investment of the substantial portion of the country resources in the development of social services, educational services, and health services. Lets try to go through some slides quickly.

Slides

These slides gives you some demographic statistics and you see as we come down there has been steady population growth to the point in 1974 where there were slightly over 2 million people. The birth rate coming down gradually and now being at about 30 per thousand population. The crued death rate having established at about 7 per thousand population. The natural increase going down slowly but still at a 2.3% growth rate. However, the overall growth rate is substantially lower than the natural growth rate and that is the result of immigration from the Caribbean some 20,000 per year in pastures that immigration has been closed down to the country such as the U. S., Canada, and Great Britian because of the world wide recession which is substantially limited. So the slow down in the growth

rate will not continue because of the restriction on the immigration. It is not surprising I am sure to anyone here that the great majority well over 90% of the population of the Jamaician of African decent and small numbers of the Indians, the Chinese and some remaining Europeans. It is a poor country, low income country with an average per capitaling income of about $800 per capative per year. Now that may sound low, it certainly is low compared to our 5600 average per capital income, but it tends to be one of the higher income countries within the Caribbean and when we think of India with the average per capitaling income of last time, I looked about $185 per year, it makes Jamaica relatively high. However, Jamaica is very much influenced as I said by patterns of living from Western countries. Its major industries are tourism, it has a substantial deposit of bauxite, it is able to produce sugar cane and is able to produce bananas. However, it is suffering very badly, obviously tourism during the recession was hit very hard. The recession hit bauxite hard and because of the two labor parties bind for each other and the elections are fears campaign in Jamaica, the two labor parties bind for the laboring population has produced a relatively high wage level for the workers. An paradoxically or ironically that makes it difficult for Jamaica's sugar to be competitive in Jamaica, bananas to be competitive on the market with other lower paying producing countries.. So Jamaica has about a 15% to 20% unemployment rate which is of great concern to its leaders and result obviously in a fair amount of social unrest especially in the large city of Kingston. Its suffering from very serious depict of payment, depicts in balance of payment, and has established recently very stringent control on the out go of funds from Jamaica. For example: No Jamaican funds can now be channeled outside of the country. Jamaicans cannot travel outside of Jamaica taking more than $50 with them. Michael Manly said that if Jamaicans are to travel at this point and time they are obliged to seek

the beneficence of relatives and friends abroad. So they are undergoing fairly stringent economic limitation, but none the less there has been a spirit over the last two years, I've been there for several weeks on three occassions of real effort to improve education, raise literacy and will talk about improvement of health services. Lets quickly go through some slides that will give you that statue of Alexander Burstmonti, the father of Jamaica, the old story of the colonial battles and the jailings and everything that went with that to seek independence from the colonial powers.

Next Slide

That is the harbor in Kingston and there are developments taking place in Kingston with regard to improving the harbor facilities.

Next Slide

That is the harbor in Montego Bay and that North coastal as you know is a very popular tourist site. There are very serious problems around tourism itself because of Jamaicas lack of arid land and because of being a developing country it needs to import very large quantities of products to satisfy the tourist, industries, and there is the neocolonialism of many of these resources being owned, the tourist hotels and other tourists activities being at least partially owned by foreign investors and again ironically the government making an effort by 5-10 years ago to gain interest in these resort areas bought in to a rate of 30%, 40% or 50% in which tourism going down the last 3-4 years the government has been faced with the foreign investors pouring out and the government being left with these resort settings. So this third world country is needing to look very hard at other ways of arrainging its economy beyond the democratic socialism that Michael Manly had been proposing.

Next Slide

There is some 30 miles inland from the north coast and do to notion to the

hills in the background but the flat lands up front.

Next Slide

That is another look not a very good slide but nonetheless the sugar cane and bananas do grow well in that area.

Next Slide.

That a very bad slide. It was taken from aircraft plane and was intended to show quite formidable terrain where there are little small villages and a little bit of hillside farming but very very difficult terrain from which to try to ringe a living.

Next Slide

This slide shows some projection. Now we are really getting into the point of time I have most intimate acquaintanceship with. Jamaica in 1964 began to have official family planning services. There was a long period of voluntary effort with regard to family planning but government services have began to become available 1964. In 1967 the National Family Act was passed and a separate national planning board was established in an effort to try to deal with the rapid natural population growth and more important the family level dangers that accompanies close basing and large family size. I should mention that in Jamaica about 50% of the union between men and women are legal unions about 30% or common law union and about 20% are what are terms, visiting relationship in which there is an acceptable but a transient relationship between a man and woman that might last several months and then terminate. Well the world bank concerned with economic development in the early 70's began to appreciate for the first time that rapid population growth would tend to deterioate or decay or dilute effort at social economic development of all other types and it has a lending agency for development. The first country that the world bank developed a loan with around family planning and indeed it was called the population and the department is still called the

population department after a period of a year or so of planning with the Jamaicians provided a loan of some two million dollars to Jamaica. That loan was largely almost entirely put to postpartum activities. The large hospital in Kingston, Victoria Jubilee Hospital, delivers about 25% about 12,000 to 14,000 babies a year. The women generally stay there for some 12 hours because of the very crowded facilities. The objective was to allow women to stay for a longer period so that the high motivation point and time for the exceptance of family planning could be responded to. With high parity births in many hospitals is reported in there and there seem to be data reliable and valid to support this some 30 to 40% of these high parity women seek sterile postpartum sterilization and a major effort was made to double the bed capacity for this large hospital in Kingston and these are some of the staff who are working at Victoria Jubilee Hospital, I think this is back in 1970.

Next Slide

The other aspect as I said family planning was a separate service, separate clinic and separate staff. I think all of you are familiar with the problem that derived from that. There was considerable rivalry and jealousy between the existing health services and its new national family planning board.

Next Slide

This with the other aspects of the world bank loan was to established rural maternity centers, again attempting to have women who deliver at home deliver with a more medical oriented setting where family planning could be made available postpartum and could be made available throughout the reproductive period. So some fifteen of these room maternity centers were built out of the 1970 loan And the woman on the left is just an incredible, competent, hardworking and responsible in Jamaica. She is an obstetrican an is now in charge of Maternal and Child Health Family

Planning and Nutrition. An 18 hours day virtually routine for her as she attempts to develop services in these areas. The woman on your right is an auxilary mid-wife.

Next Slide

Now this was the first visit I made to Jamaica. The first visit came in October 1974, four years after the original loan. Three or four months prior to that the Jamaicans had been working on a proposal for a second loan in doing that they drew on relevant ministries to establish four task forces: A task force on social demographic information to pull together as much information as they could about the island as a whole in relation to its social and vita statistic information. A nutrition task force increasing concern about the nutritional status and a human resources and a physical resources, human resources being personnel and staff and physical resources, being facility. So this was in response to a fairly dramatic shift in the world bank's position with regard to population project loan. Namely, the world bank was prepared to accept an integrated family planning service which would include broad base materman and child health services as well as nutritional services. At this visit the task force report were shared with Dr. Ronathan, an Indian physician who was the director probably the most outstanding rural health family training institute in the world a Gondegron and for the last several years has worked for the world bank. He was a member of that mission, a health planner, architect, was a member of the mission, and a food conservationist nutritionist, was a member of the mission and I was the MCH specialist.

Next Slide

This slide and I am really running out of time merely displays a sufficant amount of first degree, second degree, and some third degree malnutrition amongst the children under 5 years of age.

Next Slide

Sitting to the left of the screen is the medical officer of health the physician responsible for health services in 5 parishes : which are comparable to our countries in encompassing some 500,000 population and Dr. Ronathan is sitting on his right and this is a hammering out over a period of three weeks of those ideas that the Jamaican put forward that made up the second loan.

Next Slide

That is just an example of the small aircraft trying to get across the island and those very hilly areas.

Next Slide

Now this loan the Jamaican had been active for several years in the use for front line workers. Something similar to the front line workers in Cuba, , or the barefoot doctor in China. Unper Professor Standards leadership actually the community health aid was developed. The community health aid is a person who is able to read and write might, have no more than 5 or 6 years of education. She has six weeks of training, and trained by variety of people and not trained as this was displayed merely in a four wall room, but trained out in the homes and in the community provides basic education around MCH family planning and nutrition maintains a registry of those families in her geographic area those particularly focusing on antenatal women and children under 5 carries a hanging scale by which he weighs the infant and monitor their growth. She is able to provide and does provide first aid and she is the bridge and is the liaison between the health system. I was just very impressed with the training skills that this public health nurse has. Jamaica, I think is very favored by a good intrastructure of health centers.

Next Slide

These are closer views of these women who are for the large part are mature women who has coped relatively successfully with the mothering role.

Next Slide

This is another slide of these women sought of singing their spree decor song the work that they were engaged in, the goals they are attempting to achieve.

Next Slide

This is another slide going back to the previous slide and that area off to the left containing some 500,000 people represent an intensive demonstration area for MCH family planning and nutrition services and the ratio community health aid to population is being built up to 1,000-2,000 persons through the world bank loan, through the provision of training resources, audio visual, and to some extent back stopping with vehicles. The second part of the loan provides for the expansion of the auxilary mid-wife capacity within this portion of the island and the expansion of one auxilary mid-wife who just west of Kingston and the establishment of a new auxiliary mid-wife school in Montego Bay for the addition of 200 auxiliary mid-wives to this area bringing it to a ratio of 1 to 400 auxiliary mid-wife. The auxilary mid-wife expanding her range of services much beyond delivery to basic MCH family planning and nutrition services. The loan in addition to what I have mentioned will build 57 new health centers the number of the health centers are inadequate quality and these will be expanded over the next 5 years. It was hoped that the loan would enable the development of a supplementary food processing plant within Kingston that would provide the nutrition supplement that are currently being provided by AID that these supplements would be processed and manufactured, packaged in Kingston. There was not the capability in Kingston at this

time to accomplish that and developmental funds are being made available so that such a supplementary food can be processed and packaged and distributed directly from Jamaica. They have being used a corn soybean mix and the intent is to develop the agricultural capacity which is reasonably good and developing industrial capacity to produce and distribute the supplementary food. A very major effort is now being made to provide nationwide nutrition education mass media capaign. Finally the loan provides for expansion of postpartum programs in each of the hospitals there are some 27 hospitals scattered over Jamaica and 9 of them had postpartum programs. The loan won able expansion to all 27 hospitals and there was some other pieces to the loan. You see running through this 3 or 4 objectives 1) try to build and there is a significant evaluation system as a part of this. To build an integrated primary care system that will function much more effectively than the current one is able to function. With a focus on low cost care through the community health aid auxiliary mid-wives and a network of type 1, type 2, type 3 and a type 4 centers in each of the five parishes 2) Is to improve the nutritional status of children under 5 and pregnant lacting women and the final objective is to satisfy the world bank is a reduction in fertility through the provision of family planning services as a part of general health services. So this is really quite a remarkable shift on the part of the world bank in being prepared to provide integrated health services but still looking for reduction in fertility as an objective.

I BRING YOU GREETINGS FROM DR. HAROLD MARGULIES, DEPUTY ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION AND THE ENTIRE HRA STAFF. AS I LOOK OVER THE PROGRAM TODAY AND TOMORROW, I AM AWED BY THE NUMBER OF OUTSTANDING SPEAKERS WHO WILL MOST CERTAINLY LEAVE YOU WITH UP-TO-DATE PERSPECTIVES ON THE HEALTH OF BLACK POPULATIONS. MY PRESENTATION WILL INCLUDE THOSE CLEARLY DEFINED ACTIVITIES IN THAT PART OF THE FEDERAL BUREAUCRACY THAT I AM FAMILIAR WITH AND WHICH MAY IMPACT DIRECTLY OR INDIRECTLY ON HEALTH ISSUES IN THE BLACK COMMUNITY.

AS HAS BEEN STATED, I WORK OUT OF THE OFFICE OF HEALTH RESOURCES OPPORTUNITY (OHRO). OHRO IS AN ORGANIZATIONAL UNIT UNIQUE WITHIN THE PUBLIC HEALTH SERVICE. IT WAS ESTABLISHED BY THE FORMER ADMINISTRATOR OF HRA, DR. KENNETH ENDICOTT IN 1973. AS A MATTER OF AGENCY POLICY, THE OFFICE WAS MANDATED TO HELP OBTAIN EQUAL ACCESS TO HEALTH SERVICES, AND CAREERS, FOR ITS CONSTITUENTS--MINORITIES, WOMEN, AND OTHER SOCIALLY AND ECONOMICALLY DEPRIVED GROUPS IN THIS COUNTRY. OHRO'S GOALS ARE TO SPUR, INITIATE, INTEGRATE AND SUPPORT ACTION THAT WILL REINFORCE EFFORTS OF MAIN-LINE HRA PROGRAMS TOWARD IMPROVING EQUITY OF OPPORTUNITY TO ACCESS HEALTH CAREERS AND HEALTH SERVICES FOR OUR CONSTITUENTS. HRA IS BOTH CONCERNED WITH AND HAS SPECIAL RESPONSIBILITIES FOR THE GENERAL PROBLEMS OF HEALTH RESOURCES, THE RESEARCH ASPECT OF IMPROVING THE ORGANIZATION,

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ADDRESS MADE BY DR. CLAY E. SIMPSON, JR., ASSOCIATE ADMINISTRATOR FOR HEALTH RESOURCES OPPORTUNITY PROGRAMS (OHRO), HEALTH RESOURCES ADMINISTRATION (HRA), PHS, DHEW, ENTITLED "ISSUES OF EQUITY IN MANPOWER" TO THE FORUM ON PERSPECTIVES ON THE HEALTH OF BLACK POPULATIONS, March 30, 1977, Co-sponsored by the Black Students Caucus and the Student Union Board of the School of Public Health of the University of North Carolina at Chapel Hill--at the University.

DELIVERY, AND FINANCING OF HEALTH CARE; THE REDIRECTION OF COSTS; THE IMPROVEMENT OF QUALITY; AND THE ACHIEVEMENT OF EQUAL OPPORTUNITY FOR QUALITY CARE FOR ALL AMERICANS.

THESE LEGISLATED AND IMPLIED OBJECTIVES ARE VIEWED, BY MANY IN AND OUT OF THE PUBLIC SERVICES, AS NECESSARY HEALTH PRIORITIES OF THE FEDERAL GOVERNMENT.

AMONG THE SIGNIFICANT CONCERNS ADDRESSED IN THE HEALTH PROFESSIONS EDUCATION ASSISTANCE ACT OF 1976-- P.L. 94-484-- IS THE PERSISTENT UNDER-REPRESENTATION OF MINORITY AND LOW-INCOME STUDENTS IN HEALTH PROFESSIONS SCHOOLS. DESPITE IMPROVEMENT IN THE PAST SIX YEARS, THE RACIAL AND SOCIOECONOMIC COMPOSITION OF HEALTH PROFESSIONS STILL IS IN NEED OF BETTER BALANCE IF WE ARE TO ASSURE EQUITY OF ACCESS TO HEALTH PROFESSIONS CAREERS. THE PROGRAM OF SUPPORT FOR PROJECTS TO RECRUIT DISADVANTAGED STUDENTS INTO HEALTH PROFESSIONS TRAINING (774B) IS REPLACED BY NEW BUT SIMILAR AUTHORITY (787).

THE NEW AUTHORITY CONTINUES TO FOCUS ON IDENTIFYING INDIVIDUALS, FACILITATING THEIR ADMISSION INTO HEALTH PROFESSIONS SCHOOLS; PROVIDING COUNSELING AND PRELIMINARY EDUCATION, AND PUBLICIZING SOURCES OF FINANCIAL AID FOR DISADVANTAGED STUDENTS. THERE IS NO AUTHORITY IN THIS ACT TO PAY STIPENDS SPECIFICALLY TO DISADVANTAGED STUDENTS, ALTHOUGH THERE ARE SCHOLARSHIP AND STUDENT LOAN PROGRAMS THAT APPLY TO MANY STUDENTS, INCLUDING THE DISADVANTAGED.

THE BASIC CONCEPTUAL CHANGES IN THE NEW LAW ARE: (1) THE ADDITION OF CONTRACTUAL AUTHORITY; (2) THE ELIMINATION OF THE RESTRICTION ON THE BEGINNING LEVEL OF EDUCATION FOR THE PROJECTS; (3) THE ELIMINATION OF THE DOLLAR FORMULA AND THE ADDITION OF AN AUTHORIZATION OF $20 MILLION FOR EACH OF THREE FISCAL YEARS BEGINNING IN FY 1978.

A NEW PROGRAM OF FEDERALLY INSURED LOANS - MODELED ON THE OFFICE OF EDUCATION'S LOAN PROGRAM, AND MOST RECENTLY MOVED IN THE HEW REORGANIZATION TO THE NEW BUREAU OF STUDENT FINANCIAL ASSISTANCE IN THE OFFICE OF EDUCATION, IS AUTHORIZED IN FY 1978 FOR HEALTH PROFESSIONS STUDENTS.

STUDENTS OF MEDICINE, OSTEOPATHY, DENTISTRY, VETERINARY MEDICINE, PODIATRY, OPTOMETRY, AND PUBLIC HEALTH COULD BORROW UP TO $10,000 A YEAR, TO A TOTAL OF $50,000. PHARMACY STUDENTS, WHO WOULD BE ELIGIBLE ONLY AFTER COMPLETION OF THREE YEARS OF TRAINING, COULD BORROW UP TO $7,500 A YEAR AND A TOTAL OF $37,500.

ELIGIBLE LENDERS COULD INCLUDE HEALTH PROFESSIONS SCHOOLS, INCLUDING SCHOOLS OF PUBLIC HEALTH, A STATE AGENCY, A FINANCIAL OR CREDIT INSTITUTION, OR A PENSION FUND. INTEREST WOULD BE PAYABLE BY THE STUDENT THROUGHOUT THE LIFE OF THE LOAN AT A RATE NOT TO EXCEED 10 PERCENT, PLUS UP TO 2 PERCENT A YEAR FOR LOAN INSURANCE. THE PRINCIPAL WOULD BE RFPAYABLE OVER A 10-15 YEAR PERIOD STARTING 9-12 MONTHS AFTER COMPLETION OF TRAINING. PAYMENTS OF PRINCIPAL WOULD NOT BE REQUIRED, HOWEVER, DURING PERIODS OF UP TO 3 YEARS OF

INTERNSHIP OR RESIDENCY TRAINING, OR SERVICE IN THE ARMED FORCES, NHSC, PEACE CORPS, OR VOLUNTEERS IN SERVICE TO AMERICA (VISTA).

IN ADDITION, THERE IS AUTHORIZATION FOR A NEW PROGRAM OF SCHOLARSHIPS TO FIRST-YEAR HEALTH PROFESSIONS STUDENTS OF FINANCIAL NEED BEGINNING IN FISCAL YEAR 1978. THE SCHOLARSHIPS, WHICH WILL BE AWARDED BY HEALTH PROFESSIONS SCHOOLS, WILL BE EQUAL IN AMOUNT TO NHSC SCHOLARSHIPS, BUT WITHOUT A SERVICE OBLIGATION.

THIS SECTION WAS ORIGINALLY DESIGNED TO COMPLEMENT THE SHCOG PROGRAM IN EARLIER BILLS, ESPECIALLY IN THE SENATE. HOWEVER, DUE TO THE NUMEROUS REVISIONS AND THE LENGTH OF THE CONGRESSIONAL PROCEEDINGS, THE SECTIONS WERE SEPARATED. DEFINING "EXCEPTIONAL NEED" TO GIVE PRIORITY TO OUR CONSTITUENTS, APPEARS TO BE CRITICAL TO OUR INVOLVEMENT IN THIS SCHOLARSHIP PROGRAM.

GRANT SUPPORT FOR PUBLIC HEALTH TRAINING IN THE BUREAU OF HEALTH MANPOWER, HRA, AMOUNTED TO $20.5 MILLION IN FISCAL YEAR 1976, THE SAME AS THE FISCAL YEAR 1975 TOTAL. THE $20.5 MILLION AWARDED FOR PUBLIC HEALTH TRAINING CONSISTED OF 14 FORMULA GRANTS TOTALING

$5.9 MILLION, 80 PROJECT GRANTS, $5.5 MILLION, AND 137 TRAINEESHIPS AND NUMEROUS SHORT-TERM TRAINING INSTITUTES, $9.1 MILLION. THERE IS NO DATA ON THE NUMBER OF TRAINEESHIPS AWARDED TO MINORITY STUDENTS IN SCHOOLS OF PUBLIC HEALTH. PROJECT GRANT SUPPORT AND TRAINEESHIP FUNDS TOTALING $450,000 WERE AWARDED TO PREDOMINANTLY BLACK INSTITUTIONS.

MINORITY STUDENTS ARE UNDER-REPRESENTED IN MANY PUBLIC HEALTH PROGRAMS AND MINORITY PUBLIC HEALTH WORKERS ARE STILL A RARITY IN POLICY AND DECISION-MAKING POSITIONS IN THE HEALTH SECTOR. OHRO ENTERED INTO A CONTRACT WITH HOWARD UNIVERSITY COLLEGE OF MEDICINE IN NOVEMBER 1975 TO STUDY THE FEASIBILITY OF ESTABLISHING A SCHOOL OF PUBLIC HEALTH IN A PREDOMINANTLY MINORITY UNIVERSITY. AN ADVISORY COMMITTEE CONSISTING OF APPROPRIATE PUBLIC HEALTH PROFESSIONALS, ADMINISTRATORS, AND EDUCATORS IS DIRECTING THE EFFORT, THUS ASSURING OBJECTIVE AND RELEVANT FINDINGS. THE RESULT OF THIS STUDY WILL BE AVAILABLE THIS SUMMER.

I AM SURE THAT THOSE OF YOU WHO ARE STUDENTS IN THE AUDIENCE WILL BE EXPOSED TO COURSES THAT WILL PROVIDE YOU WITH A WORKING KNOWLEDGE OF THE LEGISLATIVE PROCESS. YOU SHOULD ALSO BECOME FAMILIAR WITH THE REGULATORY PROCESS. YOU MUST BE INVOLVED IN BOTH TO INSURE THAT FEDERAL DOLLARS SUPPORT THOSE ACTIVITIES THAT WOULD ADDRESS HEALTH PROBLEMS OF MINORITIES. NOTICES OF INTENT TO ISSUE PROPOSED RULES ON HEALTH MANPOWER PROGRAMS ARE ALREADY APPEARING IN THE FEDERAL REGISTER. YOU AND OTHER CITIZENS WILL BE GIVEN AN OPPORTUNITY TO RESPOND TO LATER NOTICES OF PROPOSED RULE MAKING.

DID YOU KNOW THAT YOU HAVE UNTIL APRIL 21, 1977 TO MAKE COMMENTS CONCERNING HEALTH MANPOWER SHORTAGE AREA CRITERIA?

NOTICE OF INTENT TO ISSUE PROPOSED RULES

- SHORT DESCRIPTION OF STATUTORY PROVISIONS AND THE MAJOR ISSUES RAISED BY THESE PROVISIONS AND DISCUSSES PROPOSED APPROACHES TO RESOLVING THE ISSUES AND IMPLEMENTING THE PROGRAMS.

PROPOSED REGULATION

NOTICE OF PROPOSED RULE MAKING

INTERIM FINAL REGULATIONS

1. PUBLIC COMMENT 45 DAYS
2. THEN PUBLISHED AGAIN WITHIN 90 DAYS AFTER THE 45 DAYS.

EACH YEAR THE ASSISTANT SECRETARY FOR HEALTH MANDATES A FORWARD PLAN COVERING A SPAN OF FOUR YEARS. THE FORWARD PLAN IS THE CULMINATION OF A YEAR-ROUND EFFORT INCLUDING THE SOLICITATION OF RECOMMENDATIONS AND COMMENTS ON LAST YEAR'S FORWARD PLAN FROM OVER 150 CONSUMER AND PROVIDER ORGANIZATIONS AND AN EXTENSIVE PROGRAM PLANNING PROCESS WITHIN THE AGENCIES OF THE PHS.

OVER THE PAST YEARS, FORWARD PLANS HAVE SERVED TWO PRIMARY PURPOSES: FIRST, PROVIDING A MORE RATIONAL BASIS FOR DECISIONS AND RECOMMENDATIONS MADE AS A PART OF THE ANNUAL FEDERAL BUDGETARY AND LEGISLATIVE PROCESS; AND, SECOND, PROVIDING THE ASSISTANT SECRETARY FOR HEALTH THE OPPORTUNITY TO PRESENT HIS VIEW OF THE HEALTH WORLD IN ORDER TO STIMULATE AND RAISE THE QUALITY OF PUBLIC DEBATE.

THE FORWARD PLAN ALSO ATTEMPTS TO PRESENT A COHERENT FRAME OF REFERENCE WITHIN WHICH THE PUBLIC HEALTH SERVICE CAN EXAMINE MAJOR HEALTH ISSUES. ISSUES OF CONCERN INCLUDE: CONTROL OF HEALTH CARE COSTS, DEVELOPMENT OF NEW KNOWLEDGE, PREVENTION OF DISEASE, IMPROVEMENT OF HEALTH CARE DELIVERY SYSTEM, AND QUALITY OF CARE.

WE BELIEVE THAT THERE ARE QUESTIONS AND ISSUES THAT A GROUP SUCH AS GATHERED HERE SHOULD CONSIDER WITHIN THE AFOREMENTIONED THEMES IN THE 1978-82 FORWARD PLAN FOR HEALTH THAT HAS ALREADY BEEN PUBLISHED AND THE 1979-83 PLAN THAT IS BEING DEVELOPED AT THIS VERY MOMENT.

LET US THEN CONSIDER THE FORWARD PLAN THEMES AS THEY RELATE TO BLACKS AND OTHER MINORITIES;

I. IMPROVING THE HEALTH CARE SYSTEM

PROBLEMS MUST BE BETTER DEFINED SUCH AS;

A. FINANCIAL BARRIER TO HEALTH CARE

B. RAPIDLY RISING TOTAL COSTS; - RATE REGULATION

C. FRAGMENTED HEALTH CARE DELIVERY SYSTEMS

D. RED TAPE OF MEDICAID AND CLINIC PROGRAMS

E. UNEVEN QUALITY OF CARE, E.G., MEDICAID MILLS

F. UNEQUAL ACCESS TO CARE, E.G., URBAN INDIANS

G. CULTURAL AND RELIGIOUS BARRIERS WHICH KEEP MINORITIES FROM HEALTH CARE DELIVERY SYSTEM

II. IMPROVING THE HEALTH CARE SYSTEM IN MANPOWER DEVELOPMENT

A. LACK OF MINORITIES AS HEALTH CARE PROVIDERS; SURVEY

DID YOU KNOW THAT SOME PEOPLE ARE SURPRISED TO LEARN THAT BLACK DOCTORS ARE MUCH MORE LIKELY TO SERVE BLACK PATIENTS THAN OTHER DOCTORS. THE RESULTS OF A RECENT AND, AS YET, UNPUBLISHED NATIONWIDE SURVEY OF AMBULATORY CARE DRAMATICALLY CONFIRM WITH EMPIRICAL DATA THE VALIIDITY OF THIS ARGUMENT. THE SURVEY, CONDUCTED BY THE NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), REVEALED THAT OVER 89 PERCENT OF VISITS TO BLACK DOCTORS ARE MADE BY NON-WHITE PERSONS WHILE ONLY 9 1/2 PERCENT OF PATIENT VISITS TO NON-BLACK DOCTORS ARE MADE BY NON-WHITE PERSONS:

B. BARRIERS TO PURSUING CAREERS AND IMPROVING CAREER OPPORTUNITIES

III. KNOWLEDGE DEVELOPMENT

1. WHAT IS THE MAGNITUDE OF GOVERNMENT-SPONSORED RESEARCH ON SUCH ISSUES AS HYPERTENSION AMONG BLACKS, CAUSE OF MENTAL DISORDERS IN THE VARIOUS MINORITY COMMUNITIES, HEART AND OTHER CARDIOVASCULAR DISEASES, ACCIDENTS, HOMICIDES, SUICIDES, CANCER, SICKLE CELL, DRUG ABUSE, ETC.?
2. WHAT METHODS ARE USED TO DISSEMINATE KNOWLEDGE GAINED FROM RESEARCH ON BLACKS AND OTHER MINORITIES' HEALTH PROBLEMS,
3. IS THERE A NEED TO SET RESEARCH PRIORITIES TO ACCOMMODATE NEEDS OF BLACKS AND OTHER MINORITIES?

IV. TRACKING AND EVALUATION

1. IS THERE A NEED TO DEVELOP SPECIAL DATA BASE FOR ASSESSING THE HEALTH STATUS OF BLACKS AND OTHER MINORITIES?

V. CONSUMER HEALTH EDUCATION

A. IS THERE A SPECIAL NEED FOR THE FORMULATION OF NATIONAL GOALS, STRATEGIES, AND PRIORITIES FOR CONSUMER HEALTH EDUCATION IN MINORITY COMMUNITIES?

B. WHAT KINDS OF HEALTH EDUCATION PROGRAMS ARE BEING CONDUCTED IN THE URBAN AND RURAL COMMUNITY HEALTH CENTERS?

C. ARE SPECIAL PROGRAMS NEEDED TO BETTER INFORM MINORITY CONSUMERS ON WAYS IN WHICH THEY CAN IMPROVE AND PROTECT THEIR OWN HEALTH, INCLUDING MORE EFFICIENT USE OF THE DELIVERY SYSTEM?

D. ARE SPECIAL PROGRAMS NEEDED TO IMPROVE THE LIVING ENVIRONMENT OF MINORITIES IN ORDER TO FACILIATE HEALTHFUL CONDITIONS AND HEALTHFUL BEHAVIOR?

E. WHAT KINDS OF KNOWLEDGE SHOULD BE DEVELOPED THROUGH RESEARCH AND EVALUATION CONCERNING WAYS OF COMMUNICATING HEALTH EDUCATION INFORMATION TO BLACK AND OTHER MINORITY HEALTH CONSUMERS?

F. SHOULD THIRD-PARTY PAYERS REIMBURSE PROVIDERS FOR THE COSTS OF PATIENTS' EDUCATION?

SHOULD THESE AND OTHER ISSUES BE VIGOROUSLY PURSUED IN THE FORWARD PLANNING PROCESS - WHICH IS DESIGNED TO PROVIDE INFORMATION PERTINENT TO ANY NEW LEGISLATION, ALLOCATION OF RESOURCES, AND SETTING PRIORITIES THAT WILL AFFECT THE HEALTH PROGRAM IN THIS COUNTRY IN THE YEARS AHEAD? IF SO, WE NEED NOT ONLY TO INCLUDE THE AFOREMENTIONED BUT ADD TO THE LIST AS YOU AND OTHERS AROUND THE COUNTRY BRING THEIR CONCERNS TO THE SEAT OF GOVERNMENT.

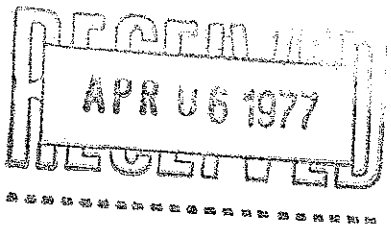
THESE ARE SOME OF THE THINGS THAT ARE GOING ON IN THAT PART OF THE VAST FEDERAL BUREAUCRACY THAT I AM ASSOCIATED WITH. I WOULD BE VERY INTERESTED IN THE OUTCOME OF YOUR DISCUSSIONS TODAY AND TOMORROW. FOR, AS A PUBLIC SERVANT, I STAND READY TO ASSIST YOU IN TRANSLATING YOUR VERBAL CONCERNS INTO ACTION ITEMS. FOR, IF WE ARE TO BELIEVE THAT "HAPPY DAYS ARE HERE AGAIN" -- THEN WE CANNOT LET THIS HARVEST PASS.

TRANSMITTAL SLIP | Date April 4, 1977

TO: William T. Sneed
Asst. Dean for Student Affairs
School of Public Health

- [ ] Approval
- [ ] Signature
- [ ] Comment
- [ ] For your information
- [ ] Prepare reply for signature of _____
- [ ] Review
- [ ] Note and see me
- [ ] Note and return
- [ ] Per conversation
- [x] As requested
- [ ] Necessary action

Remarks:



From: James W. Lea, AHTIP - Director

Phone	Room	Dept.
942-3108	406 University Square West	Carolina Populatio Center

Form No. 499

"PERSPECTIVES ON THE HEALTH OF BLACK POPULATIONS: HEALTH PROFESSIONS TRAINING IN AFRICA"

James W. Lea, Ph.D., Director,
African Health Training Institutions Project
University of North Carolina at Chapel Hill

It is clear from the presentations and remarks made to this forum yesterday and today that our interest in the health of black populations is not a purely academic one. Those professionals, students, and other concerned persons who have gathered to discuss the issues involved here are clearly not content to let this conference be merely an information and opinion sharing session. Rather, we are all concerned with taking positions and initiating actions which will positively influence the status of health among black populations all over the world. As Director of the African Health Training Institutions Project, a program of international health professional training development, headquartered here at UNC, I would like to share some thoughts about an area in which cooperative assistance from individuals, institutions and agencies can have a significant impact upon the prospects for continuing improvement in the general health of black populations. I want to emphasize at the outset that the continent of Africa is a place of immense geographical, topographical, developmental and cultural variety. It is dangerous and misleading to generalize about Africa, but because our program is involved in six countries in Africa - Ghana, Nigeria, Cameroon, Kenya, Sudan and Egypt - and due to today's time constraints, I will generalize. I am admitting it up front.

The status of health in a given population at a given time in a given place

is interdependent with a wide variety of factors. Certainly, one of the most important of these factors is the kind and quality of training received by the several categories of workers who provide preventive and curative care to the people. In most African countries, health care delivery draws upon three principle sources of direction and personnel. The formal national health care system is government-operated in most places. The system is designed and maintained by government agencies, and personnel are educated and geographically distributed by government agencies. Typically, these health workers range from those who man rural dispensaries or dressing stations, through sanitation workers, through public health professionals, health center sisters, home visitors, SRNs, and others. The quantity and quality of service thus delivered is supposedly monitored by government agencies. A second source of health care is that provided by universities. Those African universities with health professional training curricula in many cases operate teaching hospitals or similar clinical facilities. They also provide a base for private physician practice. With a few exceptions, university-based health care is available only in major urban centers. At the same time, traditional healers continue to play a significant role in most of the developing world, and this is certainly true in Africa. In some countries, traditional healing is being hounded by the modern health professional establishment, but in other countries (Kenya and Sudan) it is recognized as a viable sector of the health care delivery system, and efforts are being made through training programs directed at traditional healers to couple modern techniques with the traditional ones.

Of course, regardless of the structure of national health care systems, the efficiency of these components and others as well, is affected considerably by technological and financial problems.

All of this has profound implications for the kind and quality of training of health care workers in these African countries. At first one may think - with a unified, government operated health care system, featuring centralized design and administration - these countries need only to specify the numbers and types of workers required and then prepare educational programs to produce them. It is not that easy. There are a number of realities which inhibit such a simple, easy flow of trained health workers from the institutions to the health care delivery centers.

In the first place, I am not familiar with any African country which claimes to have a full compliment of training facilities staffed with optimally qualified faculty. Several countries are now addressing the need for physical facilities: Nigeria, for instance, is engaged in a programme to open seven new medical schools (bringing the country's total to twelve) by the early 1980's and to expand paramedical and paraprofessional training programmes. Ghana and Sudan each are building new medical schools. But no country has yet declared a solution to the problem of inadequate numbers of qualified faculty for such institutions.

A second common difficulty is the failure of communication and lack of shared purpose between those government agencies who are responsible for education of health personnel and for implementation of the service system. This factor is particularly troublesome at the higher level of professional education, such as medical schools and upper level nursing programmes, which are generally operated by Ministries of Education. At the same time, distribution of these programmes' "graduates" and operation of lower level professional and paraprofessional training programmes is generally in the hands of Ministries of Health. It is no news to anyone that inter-agency communication failures are indemic to government operations everywhere.

A highly significant inhibition to the smooth flow of personnel from training to service situations is the prevalence in many African countries of Western models for health professional training. The results in those countries are sadly the same as the results in this country. Training orientation toward professional specialization rather than toward generalization: out of country residencies and other post-graduate training: reliance upon hospital-based, not community-based, service, with a resulting maldistribution of professional personnel and, knowing as we do that education moulds attitudes as well as intellects, we are not surprised to note the great number of upper-level health professionals in African countries, who, having been trained according to Western models, react to the prospect of service posts in less desireable urban and rural areas with the same distaste as do their Western colleagues.

Unfortunately, programs of technical cooperation or assistance to many of these African countries have in the past strengthened rather than weakened these inhibitions. In the past, African countries, eager to learn and eager to improve the quality of their health professional training efforts, have willingly accepted pre-packaged and exported programmes from their Western neighbours. For example, in Tropical Africa most midwifery training had until recently been done on French and British models, using those countries' textbooks and instructional techniques. In too many cases, the European vs. African differences in cultural sensitivities relevant to the event of birth and pre- and post-natal care were overlooked. Or, another example, a medical professor in a major West African medical school complained to me recently that his country is now gifted with an entire generation of Western-trained medical specialists who have returned to their home country and now insist upon practising open-heart surgery or hand-reconstruction

in a country where thousands suffer from causes related to malnutrition and the lack of basic hygiene.

Fortunately, those times are passing. Western models still prevail in many countries at the upper levels of health professional training, largely through those countries' "desire" to build and maintain academic credibility among their international colleagues. However, most countries have recently developed a sense of urgency in their understanding of the needs to develop training systems which relate directly to the health care needs of a population. In the Sudan, for example, the government has recently undertaken a programme to train 4,000 community health workers who will man village-based care centers in all provinces of the country. Kenya has changed the name, the function and the training curricula of one important segment of its nursing services. The former enrolled level nurse is now the community health nurse. Training programmes and training sites are being established which relate to the urban and rural communities in which these community health nurses will serve. Nigeria is embarked on a programme costing the equivalent of several billion Dollars to train and assign several new categories of primary care workers, most of whom will be posted in village health centers throughout the country.

At the same time, even the higher level nursing and the medical curricula are undergoing review and revision in many countries. The first generation of totally in-country trained doctors and nurses is now being graduated in many countries in Africa. In addition, many health professional curricula are broadening their scopes and attempting to make educational approaches and settings realistically revelant to local health needs. To go back to the Sudan, the Faculty of Medicine, University of Khartoum, has long maintained the best British tradition in its curriculum. Within the past two years, how-

ever, this medical faculty has adapted a multi-departmental programme in family health teaching, which is designed to train medical students attitudenly as well as cognitively to provide care, with the family as the basic unit of practice and the community as the basic contex. The University Center for Health Sciences in Yaounde, Cameroon, has for several years been training medical, nursing and allied health students side by side in community clinic settings throughout the country. Ahmadu Bello University, in Zaria, Nigeria, has thus far resisted building a central teaching hospital for health professional training. Instead, medical and paramedical students get all of their clinical experience in community clinics, very similar to those in which they are expected to serve upon graduation. In these and other countries throughout Africa, a process of re-thinking and re-orientation on the part of those who plan and operate health personnel training systems, is beginning to bear significant fruit.

An increasing number of developing countries, in Africa and elsewhere, become convinced that Western models of health professional training are really not as relevant to their national needs as they once thought. Where does this leave those of us in the United States and other industrially developed countries who are sincerely concerned with the quality of health care available to the world's many populations? Are there ways in which men and women, governments, institutions and others can provide meaningful encouragement and support to health care development in Africa? Or should we withdraw from that arena completely? And rest assured that our African colleagues have identified their own ways and means for producing sufficient numbers of sufficiently trained personnel to tend to their country's "health care needs". Along this line, should we perhaps, as many have suggested, put our own house in order with regard to the health of all sectors of our own population rather than focusing interest and resources upon the health care

problems of other countries?

Despite the urgent need to attend to improved health care for all of our own people, there are still things that the health professions in this country can and should do to support the efforts of their colleagues in Africa. In an address to the 1971 Kampala conference on the Teaching and Practice of Family Health, Prof. G.L. Monekosso, Director of the University Center for Health Sciences in Yaounde, predicted that within the decade every country in Africa would have its own medical school. His implication was that every country would also have begun to tailor its own system of health care delivery and supportive training institutions. Prof. Monekosso further observed the necessity for each African country to design such systems in direct response to real health care needs, as expressed by the people of the country. In that process, interested outside agencies - governments, institutions and others - must accept a supportive rather than a directive role. This means that "cooperation" between countries in health professional development takes on a more concrete and objective definition. It means that "assistance" must be construed as assisting African countries to do what they need to do, not what we think they should do. It means our support to intra-country and inter-country training and exchange of consulting professionals in Africa, rather than an insistence upon bringing the very best people out of their countries for some purposes of a higher world good.

Of equal importance to the health of the American black population - in fact, the population at large - it means the development of a new willingness on the part of the American health professions to listen to and learn from our African colleagues. Many countries are years beyond ours in the concepts and practices of training and using so-called physician extenders

and other kinds of paramedical primary care providers. International co-operation in health care development should mean that the Western nations, certainly the U.S., take a close look at the innovations achieved by our African colleagues in broadening the base of the care system and at the successful results of their willingness to experiment with new teaching and service models. In this way, our international professional relationships become a two-way communication channel, with positive results for the health of black populations on both sides.

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THE ROLE OF BLACK FOLK MEDICINE BELIEFS AND PRACTICES IN HEALTH CARE

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March 30-31, 1977

The Role of Black Folk Medicine Beliefs and Practices in Health Care

INTRODUCTION:

Every known culture have among their attributes a body of beliefs and practices concerning the recognition and treatment of illness. In most cultures this includes persistent or residual, and often unsuspectingly, widespread beliefs and practices in folk medicine and other non-scientific health practices. Thus, despite the scientific and technological revolution, even Western cultures have not completely abandonded or eradicted adherence to these beliefs and practices. Our observations indicate that there may be an increase in the incidence and prevalence of the use of folk medicine occuring. This increase seems to be taking different directions with different groups, e.g. higher socioeconomic young people seems to lean toward health fads and meditations while lower socioeconomic youth seem to lean toward roots and herbs.

In this paper, folk medicine will be defined as those health care practices which has been developed mostly out of beliefs and usage over time and handed down from earlier generations or may have been borrowed from other cultures. In contrast scientific medicine is defined here as that which is prescribed by the trained professional in the medically recognized educational system.

It may be noted that these systems of medical care beliefs are not mutually exclusive.

One of the main differences between the other folk models and the biomedical model has to do with the inferred etiology of disease in these folk or non-scientific health care systems. These systems represent culture-ecological residues of perhaps an earlier, and certainly different time.

The ascribed and attributed causal agents in these systems are purportedly more overwhelmingly supernaturalistic and more personal, as contrasted with the scientific biomedical model, in which causality is largely inferred or derived from either naturalistic processes, chance or accident according to Brody. There are also other important differences between the two orientations which are diagnostically and therapeutically, and perhaps even more, psychologically according to Foster.

The purpose of this discussion is to examine the folk medicine system as practiced and believed by Black Americans especially in the south. Generally, the usefulness for studying folk medicine is at least to fold. First it may be studied to examine various aspects of treatment and healing procedures and second, it may be studied with the intent to focus on those areas where the contrast with scientific medicine might produce conflict and or prove harmful to the patient (Snow, 1973). We can see then that we may look at other systems of health care in order to gain information as to how these alternative forms may (a) interact with (b) affect (c) enhance or complement (d) detract from and (e) impede or negate the curative and preventive thrusts of officially recognized medicine. The ultimate purpose is to provide information on the socio-cultural and psychodynamic processes that are involved that assure or promote the tendency of these health beliefs and practices, so as to minimize conflicts and maximize cooperative understanding with the officially recognized health care and treatment system.

THE OBJECTIVES ARE TO:

1. Describe broadly the characteristics of those who practice and believe in folk medicine.
2. Estimate the prevalence of the use.
3. Note some of the home remedies and rituals including natural and superstitions.

4. Suggest ways in which the use and belief in folk medicine may be useful or harmful.

HISTORICAL BACKGROUND:

The folk medicine system as practiced and believed by American blacks is reported to be a composite of African and early European folklore. It has elements of the Voodoo religion of the West Indies, tenants of fundamentalist Christianity, and magic.

During the times when the slaves were being shipped to the Americans there existed throughout Africa an established and well accepted group of native healers who provided practically all of the treatment for the ills of their people.

African slaves brought with them their beliefs and practices of how to treat and cure illnesses. Since some of these treatments were not understood by the white masters, they oftentimes had to be practiced in a clandestine manner according to (Herkovits). These practices have been modified to suit the new environment and continues at varying levels.

THE FOLK MEDICINE HEIRARCHY:

Folk medicine is observed to be practiced in varying ways, and, of course, at varying levels of prevalence. Like formalized medicine there exist a hierarchy of practice. For example, the physicians stands at the top of the hierarchy in formalized medicine while various para-professionals are at the lower level. In black folk medicine the various folk healers seems to be at the top of the hierarchy while those specializing in making special medicine for a minor condition, are at the lower level. Noted among the recognized healers at the top of the hierarchy are herbalist, root doctors, medicine men, voodoo doctors, conjurers and so on.

The prevalence of healers among the black population is unknown, however, it is noted that the healers practice is dependent upon the belief as to the cause of the illness. e.g. if the illness is considered to be of natural causes a medicine man, herbalist, or root doctor might be called upon. However, it the illness is considered to be of unnatural causes such as a hex, or fix, or sin or evil spirit, then a voodoo doctor, or conjurers, or faith healer may be called upon. In the former medical treatment may take the form of medicine made from roots or herbs, while the latter maybe a ritual or ceremony that may be mixed with roots and herbs. The works of these healers are not mutually exclusive since they may practice both natural and unnatural system simultanuously. In this case they may act similar to general practitioners in the formalized medical system.

Another level of folk medicine are those special people who have learned to prepare a special type of medication for a special condition. There usually is a family member in most black families that fits this description. In many black families, when someone falls ill, if the symptoms are not severe a home remedy (usually herbs and salves) may be administered by oneself or a family member, oftentimes the mother. The family member administering the home remedy may be seen as the lowest in the folk medicine hierarchy.

CHARACTERISTICS OF FOLK MEDICINE USERS:

As far as we can determine folk medicine is used by virtually all age groups, both sexes and every class of Black Americans. The broad range of people who believe in or use folk medicine may reflect the depth with which folklore have presisted. Folklore in terms of superstitions and popular beliefs is not the preserve of the unlettered only, but is a state of mind or a way of looking at things that may befall even the most sophistocated member of society.

The incidence or prevalence of the use of folk medicine also is not known, however, Snow conducted a study of folk medicine systems among low income Black Americans and Spanish Speaking and found an extensive use of folk medicine. He felt that the lack of adequate health care facilities and religion mostly accounted for this pattern of use, he stated that:

> "As more and better health care is made available to the poor patient, some of these beliefs will gradually begin to die out. Those intimately tied to religious beliefs in witchcraft, may continue to be operative as long as the spanish speaking or Black American is economically and socially marginal".

To gain some feeling for the extent of use of folk medicine by those other than the low socioeconomic level, I conducted an unscientific survey. The population consisted of a selected sample of faculty staff and students of Meharry Medical College. I reasoned that those working in the formalized medical system may be least likely to use an alternative medicine systems.

Fifty persons were interviewed. All but four were women. The population included two female medical students. It was intended at the outset that only female students would be interviewed. However the four males were interviewed due to a miscommunication to one of the interviewers, (1) all of the respondents had a high school degree or above, (2) twenty five percent had a college degree, (3) all but one was under forty five years old, (4) forty two percent of the population were users of folk medicine and (5) more than half of the respondents knew someone in their family that had prepared home remedies either for them or for someone in their family.

Some of the home remedies used by the respondents were as follows:

Homey and Lemon and Whiskey-tea	Colds
Alcohol and Water	Temperature
Warm Salt and Water	Sinus
Garlic Cloves	Blood pressure
Eucolyptus Oil and Honey	Colds
Fat Meat or Potatoe	Boils
Raw Eggs	Boils
Penny and Chewed Tobacco	Rusty nail wound
String tied on leg	Cramps
Keys	Bleeding nose
Beer	Prevent worms
Kerosene and Sugar	Colds
Silver dollar and belly band	Petruding Navel
Mustard seed	Asthma
Dirt, Clay Rocks	Contraceptive
Standing on head	headaches

Home remedies that have been noted to be in use generally covers a broad range of practices and rituals and have been noted in several publications such as (Popular Beliefs and Superstitions from North Carolina-The Frank Brown Collections of North Carolina Folklore). (Superstitions and home remedies encountered in present day pediatric practices in the South (Journal of Kentucky State Medical Association, 61. 1963).

THE USEFUL OR HARMFUL EFFECTS OF FOLK MEDICINE:

In viewing folk medicine in its broadest range today, we may consider health practices from the use of teas to relieve a cold, to the use of vitamin C to prevent a cold as folk medicine. The use of health spas and special exercising may well be the new form of health practices entering into the folk medicine system of beliefs.

Other systems of health care that may compare with or may be supplementing forms of folk medicine practices are Faith Healing, Meditations, Astrology, Palm Reading, etc. The adaptation of Eastern forms of healing systems (Meditations such as Yoga, T.M., acupuncture) has made vast inroads into middle and upper socioeconomic levels of our society, especially from the standpoint of it's psychotherapeutic potential. Thse meditations may well be thought of by some individuals as a means of coping with anxiety in lieu of, or in addition to their utilizing components of the conventional liscensed health care and treatment system (Otis, Schwartz, Campbell[19]). In any case alternative systems of health care are receiving additional attention as indicated by the various conferences across the country that occurred last year.

The question of whether folk medical practices interfere with formalized medical treatments are not fully answered. Laudell Snow states that folk medicine beliefs <u>are</u> at odds with scientific medicine in many respects. He notes that:

(1) The beliefs about the intricate network linking man to the and supernatural world may greatly color the doctor/patient relationship and influence the decision to follow-or not-the doctor's orders.

<u>Other authors notes that</u>:

(2) The user of home remedies may rely upon the self medication initially, thus delaying his arrival to receive professional health care. This may affect his chances at survival or recovery.

(3) Some patients may be using home remedies while receiving treatment from the physician. These home remedies may interfere with the treatment of the physician.

(4) When ritual and ceremonies are used in the treatment or curing processes, some authors note that ritual trinkets foster superstitions and can be expensive.

Some behavioralists note that there is a growing awareness among people working in the mental health field that some groups in the community maybe helped by therapeutic processes outside the formalized health system, and that the knowledge of folk healing might provide those who work in the mental health professions with a better understanding of particular ethnic problems. Knowledge of the belief systems of the patient are important for a psychotherapist if they are to distinguish correctly between what is an idiosyncratic delusional system or hallucination and what is merely part of the patients world view (Garrison).

Healers are generally though of as having their greatest effect in the mental health area since they often provide continuing support for those with borderline behavior disorders and others who are ill in the community in a way which modern psychiatry cannot.

Torrey notes that the witch doctor and the psychiatrist are in the same trade. That recognition of this should not down grade the psychiatrist, but upgrade the witch doctor. (Torrey, 19)

Students of folk healing believe that there are many advantages to greater understanding between and integration of traditional and non-traditional methods of healing. This understanding enables the professional to begin to treat the patient in his own world of beliefs and understaning, so that the recognition that the informal organizational or institutions (such as that of folklore) in the community in as real as the formal system is another step in the direction of better health care.

BLACKS AS SUBJECTS OF HUMAN EXPERIMENTATION**

by

William A. Darity, Ph.D.*

INTRODUCTION

The issue of blacks as objects of human experimentation has taken on new dimensions in recent years. This is closely associated with the concept of informed consent in the use of experimental drugs. Also, blacks seem to be the most vulnerable group because of their low economic status, the high rate of incarceration, and a high predominantly white professional community who not only directs and supervises research in human experimentation but who also control the entire field.

INFORMED CONSENT AND VULNERABILITY OF BLACKS AND OTHER MINORITIES

The concept of informed consent should be applied just as the term indicates, that is, an informed individual, who willingly participates in a human research project, with the awareness and understanding of potential hazard, possible lack of effective results, potential side reactions and other risks involved. The individual should be informed of the type of agency or organization and should have an understanding of the functions of the agency or organization sponsoring the research, the name and background of the principal investigator and the special contact person in cases where an emergency may arise.

The issue of informed consent is crucial for prisoners, children, the mentally ill, and for the poor. This is particularly true in the United States where minorities form a very high percentage of those incarcerated

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and blacks, native Americans, and Spanish surnamed Americans form a very high percentage of those in the poor category. According to Ingelfinger, "By some estimates it is believed that possibly 80 percent of all human experimentation which has occurred in this country involved the poor."[1] Katz also points out that

> Human experimentation can be hazardous to its subjects. Thus it is not surprising that the economically socially disadvantaged are conscripted for research to a disproportionately large extent. Throughout history the poor have been indentured for society's most disagreeable tasks, and medical science has only followed time-honored patterns of recruitment.[2]

The life situations of minorities make them more susceptible to being coerced into participating in research projects particularly since both poverty and physical numbers can have an impact on any decision which they make.[3]

SOME CASES OF BLACKS IN HUMAN EXPERIMENTATION

There are cases which can be cited where informed consent was not provided. The most notorious of these is the "no treatment" syphilis study conducted among 600 black men who were suffering from syphilis in Tuskegee, Alabama.

> The men were given no treatment so that study could be made of the normal course of untreated syphilis in man. The study was supported by the United States Public Health Service...
> This study commenced in 1932 and it was not until both the national and international press published the information in late July 1972, 40 years later, that it was made known. At least 28 to 100 men are known to have died as direct result of no treatment in this study.[4]

It was not until there was both national and international press coverage that it was openly admitted that this large-scale human experiment had been carried out.[5] The critical issue and ethical concern was not only that the study population was not informed in any way but in addition,

earlier in the 20th century studies in Scandinavia had already provided evidence of what happens to persons who go untreated for syphilis.[6] In other words the research was not needed in any form to provide new information which would benefit the public.

Another example of the use of minorities in human experimentation is reported in a California research project. This study was conducted in Los Angeles County hospital in 1957-59. According to Randal,

> Most of the patients, then as now, were poor and either Spanish-American or black. The aim was to determine whether antibiotics given on a routine basis would improve the chances of survival for premature babies.
>
> The study showed that babies receiving no drugs or babies given only streptomycin and penicillin had the best chance of survival - 4 out of 5. The groups receiving chloramphenicol or chloramphenicol in combination with penicillin and streptomycin fared less well.[7]

Of 30 receiving chloramphenicol, 18 or 60 percent died. Of 31 receiving chloramphenicol in combination, 21 or 68 percent died.[8]

A follow-up study was made at the same hospital in 1959 and the study demonstrated that six more premature infants were given chloramphenicol and all six died from a constellation of symptoms which resulted in the collapse of their circulatory system.[9] The same sequence had been noted in patients treated for typhoid fever with chloramphenicol.[10] Randal implies that the study was prolonged in order for medical statisticians to get enough significant cases.

The use of Mexican American women in a contraceptive pill experiment in Texas in 1969 is well documented. Not only were 76 patients of the 389 total in the study give placeboes, while thinking they were being given contraceptive pills, those who became pregnant were not provided abortion services when they requested it.[11]

Gray[12] analyzed findings related to a labor-induction drug study. His interviews were carried out in the labor room. He observed that not all of the subjects in the study knew about the research in which they were participants. This was partly due to the procedures of informing patients. Their first explanation was in the hands of various private or house staff physicians who had first selected the subjects for the study. Others were informed while in the labor room.

In his study Gray found that 50 percent of the private patients knew of the research prior to admission as compared to 34 percent of the clinic patients. It was observed that 25 percent of the private patients learned of the research while in the labor room compared to 16 percent of the clinic patients. And 50 percent of the clinic patients did not know when their participation began in the study as compared to 25 percent of the private patients.

When subjects were compared on a racial basis, a highly disportionate disparity emerged. Gray found that 50 percent of the white private patients became aware of the research before admission, the other 50 percent after admission; that 69 percent of the white clinic patients became aware of participation before admission and 31 percent after; and that 11 percent of the black clinic patients were aware before admission and 89 percent after admission. See Table I for these results.

TABLE I

Gray's study: Awareness of Research by Private-Clinic Status by Race (Labor-Induction Study)*

Patients	Before Admission	After Admission	(N)
White private	50% (8)	50% (8)	16
White clinic	69% (9)	31% (4)	13
Black clinic	11% (2)	89% (16)	18

*Extracted from page 68 (Table 4), Bradford H. Gray, Human Subjects in Medical Experimentation, John Wiley and Sons, Inc. 1975.

In order to assume that these differences were not due to education, Gray analyzed these data to determine if this was a factor among the clinic patients only, since there were no blacks among the private patients. He based his analysis on high school graduates or high vs. less than high school. His study showed that among white clinic patients with high school or more education, 86 percent learned about the research before admission while among blacks 25 percent learned before admission.

He observed that among those with less than high school education, 50 percent of the whites were informed before admission while among blacks, none were informed. Table 2, provides this information.

TABLE 2

Gray's study: When Learned of Research: Clinic Patients by Race and Education (Labor-Induction Study.)*

Subjects	Before Admission	After Admission	Total
White			
High school or more	6 (86%)	1 (14%)	7
Less than high school	3 (50%)	3 (50%)	6
Black			
High school or more	2 (25%)	6 (75%)	8
Less than high school	0 (0%)	10 (100%)	10
Total	11	20	31

*Extracted and modified for percentation from page 69 (Table 5), Bradford H. Gray, Human Subjects in Medical Experimentation, John Wiley and Sons, Inc. (1975).

In this study, the issue of real informed consent is questionable since the labor room does not seem to be the "most desirable" place to request consent to participate in any human experimental study on the use of pharmacological drugs. The request of participation of a woman could give the impression to the subject that she must participate - therefore implying a form of coercion rather than voluntary informed consent.

Gray's study clearly illustrates how clinic patients can be used in experiments and it further illustrates the differential level of informing patients when compared on a racial basis.

In addition to the racial or ethnic minority issue, low income or poverty enters into the study. The very widely read clinical field trails in Puerto Rico is a classical example. In one of these field trails there were 265 Puerto Rican wives from a low income population group. They lived in a housing development project. In analyzing the content of the structure of the study, there is no indication that totally informed consent was provided and particularly that the subjects were aware of the possible side effects from the oral contraceptive.[13] However, it was less than 13 years after the first clinical trail run that Lipsett et al, pointed out the effects of estrogens on renin substrate, angiotensin and other plasma proteins and the relationship of these effects to potential hypertension.[14]

It has also been observed that researchers will withhold information from subjects on the basis that information will create anticipation and suggestion, and therefore cause the patient or the subject to provide false information. The ethical aspect of withholding information on the grounds that it will create suggestion has been questioned and argues extensively. In order to analyze this aspect of ethics in health care and related research the author of this paper carried out a study in Charlotte, N.C. in 1961-62, to analyze what happened to patients where information on side effects were withheld with regard to the oral contraceptive. An analysis of the educational sessions revealed that the patients were only informed that they might expect "break through bleeding," from the use of the oral contraceptive. The follow-up study elicited information in which they were asked to describe to the interviewer what really happened to them when they started taking the oral contraceptive.

The patients description of what happened to them is as follows: drowsiness, dizziness, nausea, vomiting, headaches, weight gain, nervousness, and slight or heavy bleeding. Of the 107 women followed up, 78 or 73% claimed side reactions. (An unpublished Ph.D. dissertation by William A. Darity, Contraceptive Education: "The Relative Cultural and Social Factors Realated to Oral Contraceptives," 1963).

The clinic in Charlotte, N.C. where the study was carried out, was operated by Charlotte-Mecklenburg Health Department. Approximately 85 percent of the subjects were black and all were from the low income class.

The ethical aspect of informed consent is questioned expecially since there was already considerable information regarding side reation and what could be expected. The "claimed side reactions: by subjects in the Charlotte study, were high compared to other studies. However, because of the low education level and the lack of reading, the self-description, provided by the subjects should be taken as valid and not "suggestions." A related study earlier demonstrated that in a group of 551 women in Puerto Rico there was an incidence of 45 percent nausea.[15] In another study at the same time it was pointed out that there were 28 percent cases of headaches in Humacao, Puerto Rico, and an incidence of 17 percent vomiting among another group of women and weight gain among 25 percent of the women in the study.[16]

These latter studies support the issue that the patients in the Charlotte, N.C. program should have been informed about the possible side reactions.

These cases do not illustrate private physician involvement in health care research and how patients are used and never informed. However, the close relationship between the private physician and the pharmacology industry and their research projects should be considered and recognized as a gap that must be closed to assure ethics in human experimentation in this domain. This becomes more evident where the multinational corporations are concerned.

A case in point is the experimentation at the McKere University Medical School in Kampala, Uganda between 1966 and 1971 on prostoglandins. Large numbers of Ugandan women were used in these experiments in which prostoglandins were used in these women to bring on menstruation, labor, or abortions.[17] The work for these studies were supported by the Wellcome Trust, U.K., the Upjohn Company, Kalamazoo, Mich., the McKere University Research Grants and the Maljibhai Madhvani and Co. Ltd, Uganda. Prostoglandins were provided by Professors Bergstrom and Samuelsson of Sweden and the Upjohn Company of Kalamazoo.[18] Evidence is to be demonstrated that these women were truly [redacted]informed or that they did understand what was happening to them.

The cases cited further lead to some specific issues that relate to blacks and other minorities and some suggestions for special plans and steps to protect them from coercion and potential tyranny.

SPECIFIC ISSUES WHICH WARRANT PLANNING TO ASSURE PROTECTION OF MINORITIES

In discussing the findings of the labor-induction drug study, Gray observed that when education was equal, white patients were more informed. He states:

> The main conclusion is that information about the study was better communicated by the house staff to patients who were relatively similar to themselves with respect to race and education (no involved house staff physicians were black.).[19]

He further points out that the explanation of variation in difference in knowledge about the research should not suggest that the subjects are responsible, as there is little doubt that it is the responsibility of the researcher or principal investigator to communicate relevant information to research participants.[20]

It is the responsibility of the principal investigator to be assured that subjects understand clearly the nature, purpose and method of the reasearch.

Of particular concern to minorities is the manipulation of the situation to acquire participation in a study. According to Kelman, the ethical issue is concerned witn "the view that any manipulation of human behavior inherently violates a fundamental value."[21] Kelman further states that:

> To be fully human means to choose...I therefore regard as ethically ambiguous any action that limits freedom of choice whether it be through punishment or reward or even through so perfect an arrangement of society that people do not care to choose... First, I can try to show that the desire to choose represents a universal human need which manifests itself under different historical circumstances (not only under conditions of oppression). Second, I can point out that freedom of choice is an inescapable component of other valued states such as love, creativity, mastery over the environment... Third, I can try to argue that valuing free individual choice is a vital protection against tyranny...[22]

The latter point of tyranny of the majority against the minority develops the basis for special arrangements and concerns for minorities in human experimentation.

Data show that in unemployment, low occupation characteristics, low income, selected health indices and poverty, black Americans and other minorities are disproportionately represented. For example, in

April 1973, the ratio of unemployment for all workers was 4.8 percent. It was 4.3 percent for white workers and 8.7 for blacks and others, a differential ratio of 102 percent.[23] See Table 3. In 1974, the ratio was approximately 8 percent for all workers and over 15 percent for black and others.

In the first quarter of 1975 there were over 716 million persons unemployed in the United states. This represented 715 percent of the total employable population. Of the total numer unemployed, 1,425,000 were blacks and other races. This was a ratio of 13.7 percent of the employable population. For the white population the ratio was 7.6.[24] The ratio was a deficit ratio of 30% for the non-white population of the U.S.A.***

Correlated closely with the high rate of unemployment is the distribution of those actually employed by types of occupations. In 1974, of the 85,936,000 persons employed in the United States 9% were black. Six percent of the total in white collar were black, 12% in blue collar jobs were black, 19% of the service workers were black, 7% of the farm workers were black, 13% of those in durable goods were black and 21% of those in personal services including private households were black. These figures are not consistent with the black population base of 11%. On the other hand there is a slight over representation in numbers in health services and education.[25] In health services, however, the major proportion are in the aide non-professional category.

INCOME

Another indice which illustrates the social inequities in the United States is income of black Americans. In 1969, the median income for white families was $9,794, while for black families the income level was $6,191 or a deficit of $3,603 with a differential deficit ratio of 59.6%.[26]

In 1971 the median income for white families was $10,672, while for blacks and other minority families the income level was $6,714 or a differential deficit ratio of 59 percent.[27]

> In a direct comparison between white families and black families, the median income for whites was $10,672 and for blacks $6,440 almost $250 less than when blacks are included with other minorities. This reveals that blacks have the lowest income of all minority groups in the United States. The income deficit is $4,232 and the differential deficit ratio .66 or 66%.[28]

In 1974, the median income for white families was $13,356, while for black families the income was $7,808, or a deficit of $5,548 or a differential deficit of 71%. This demonstrates an absolute decrease in economic capability of blacks.[29]

It is obvious that as we review employment and income in the black community, the evidence indicates the need for special procedures to protect them and other minorities from coercion and abuse.

A SUGGESTED PROTECTION PROCEDURE[30]

To be assured that there will be adequate attention given to minority subjects in human experimentation and research in health care delivery, and also to assure that they will not be coerced in participating, the following proposals should be considered:

(a) The establishment of a Special Permanent Sub-Committee of the Commission, made up of minority professional and lay-persons who will be concerned with reviewing standards and guidelines to be sure that the minority interest, particularly, informed consent is included and is adequate.

TABLE 3

Unemployment Summary: 1970 to 1973

Subject	1970	1971 April	1973 April
Unemployment rate (percent):			
All Workers	4.9	5.8	4.8
White	4.5	5.2	4.3
Male	4.0	4.8	3.9
Female	5.4	5.9	4.9
Black and other	8.2	9.3	8.7
Male	7.3	8.1	7.9
Female	9.3	10.8	9.7
Ratio, Black and other to white	1.8	1.8	2.0
Blue-collar	6.2	7.6	5.4
White-collar	2.8	3.3	2.8
Experienced wage and salary workers	4.8	5.5	4.5
Married men, wife present	2.6	3.2	2.5
White	2.4	3.1	2.3
Black and other	3.9	4.2	4.1

Source: U.S. Department of Commerce, Statistical Abstract of the United States, 1971 and 1973.

(b) Minorities in sufficient numbers with the background and depth be placed on all review committees of NIH; that such persons be reviewed and given approval by an outside group of minority professionals to assure that their credibility and interest are accepted.

(c) To protect medicaid and medicare patients from unknown and unwarranted participation in human experimentation by clinics and private physicians, a statement of assurance be required on all payments and this form a part of PSRO standards and review.

(d) Establish special standards and guidelines to assure that language, educational background, socio-economic status and cultural heritage, be considered and taken into account when informed consent is requested of minorities to participate in human experimentation.

(e) Develop guidelines so that each research proposal will explain the population constituency, staffing patterns and approaches which will be used to assure clarification and understanding of minorities and their participation in studies.

(f) In evaluation performance of research projects in which human experimentation is carried out, included will be special standards for assuring the protection of minorities. This should ascertain how they were recruited, state and time of request for participation with signed agreements specifying time and place and contact person.

CONCLUSION

Human experimentation in health care delivery will continue to be carried out. This is often considered essential in the improvement of health care. However, human dignity must be preserved through ethnical standards. This is particularly true for blacks and other ethnic minorities who find themselves in a disadvantaged position because of both economics and numbers. They usually use public clinics more than the majority population. In this connection special standards and guidelines, and special requirements must be established to assure that Black Americans, Puerto-Ricans, Mexican-Americans, Asian-Americans, and Native Americans will not be exploited and become victims of tyranny of the majority controlling researchers in human experimentation.

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1. Franz Ingelfinger, "The Poor," Experiments and Research with Humans: Values in Conflict. National Academy of Sciences, Washington, D.C., 1975, pp. 150-170.

2. Ibid. See Jay Katz comments in the above documentation.

3. Ibid.

4. See William A. Darity, "Crucial Health and Social Problems in the Black Community," Journal of Black Health Perspectives, June/July 1974, pp. 30-50 for other information which points out economic and social inequalities and supports the vulnerable position of the black community.

5. Examples of articles which appeared on both a national and international basis are as follows:

   "Alabama Man Learns of His 40-Year Syphilis," International Herald Tribune, Paris, Friday, July 28, 1972.
   "Indignation Aux Etats-Unie Apres la decourtete du programme d'experimentation" peu des Noirs, Le Figaro, Vendredi 28 Juillet 1972.
   "Sex Illness Guinea Pigs Left to Die," Daily Mail, Friday, July 28, 1972.
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   "Black Caucus Demand Reparations for Victims of U.S. Syphilis Study," Jet, Vol. XLII, 21, August 17, 1972, 14.
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9. L.E. Burns, J.E. Hodgman and A.B. Cass, "Fatal Circulatory Collapse in Premature Infants Receiving Chloramphenicol," The New England Journal of Medicine, Dec. 24, 1959, 1318-1321.

10. See Editorial Comments, "Blood Dyscrasia Following the Use of Chloramphenicol," The Journal of the American Medical Association, Vol. 149, June 28, 1952.

11. Eileen Adams and Geoffrey Cowan, "The Human Guinea Pig: How We Test New Drugs," World Magazine, Dec. 5, 1972, pp. 20-24. This article points out how blacks and other minority in state prisons are used as guinea pigs, it describes the Tuskegee "no treatment" program; it describes the chloramphenicol study, and other programs including a planned parenthood project in San Antonio, Texas, in 1969, where 389 women participated in a pill study, mostly Mexican-American, where 76 were give placebos.

12. Gray, op. cit. 59-69.

13. See G. Pincus, J. Rock, C.R. Garcia, E. Rice-Wray, and I. Rodriguez, "Fertility Control with Oral Medication," American Journal of Obstetrics and Gynecology, 77, 1333-1346, 1958.

14. M.B. Lipsett, J.W. Combs, Jr., D.G. Siegel, "Problems in Contraception," Annals of Internal Medicine, 74, 251-263, 1971.

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16. J.W. Goldzieher, L.E. Moses, and L.T. Ellis, "A Field Trail with Physiological Method of Conception Control," in Clyde V. Kiser (ed.) Research in Family Planning, (Princeton, N.J., Princeton University Press). pp. 353-355, 1962.

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21. Herbert C. Kelman, A Time to Speak: On Human Values and Social Research. (San Francisco: Jossey-Base, Inc. Publishers), 1968, p. 15.

22. Ibid, 17-18.

23. U.S. Department of Commerce and the Department of the Census, Statistical Abstract of the United States, 1971, 1973.

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26. U.S. Department of Commerce and Bureau of the Census, Statistical Abstracts of the U.S., 1971, p. 233.

27. Op cit. U.S. Department of Commerce and the Department of the Census, 1971, 1973.

28. Op cit. Darity.

29. Op cit. U.S. Department of Commerce, The Economic and Social Status, 1975, p. 33.

30. For a more detailed outline see paper by William A. Darity, "Ethics in Human Experimentation in Health Care Delivery," The National Minority Conference on Human Experimentation, Ruston, Va. January 6-8, 1976. This aspect was extracted from the above paper.

Conference Participants

name, title
position
dept or school program
location

(5)

University of North Carolina Officials

Dr. William Clyde Friday, President

Nelson Ferebee Taylor, Chancellor

Vice Chancellor

Health Sciences

[illegible] School

School of Public Health,

Dr. Bernard G. Greenberg, Dean

Conference Planning Committee

Janet Miles

[illegible] Dougherty

Sheri Milan

Doris Megwood

Rosyland [illegible]

Milton Gunn

William Small, Dean of [illegible]

(6)

Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health of the University of North Carolina at Chapel Hill.

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200 copies

Artwork furnished to come in later

[illegible]
Black Populations

[illegible] 1977

2

Program

Wednesday - March 30, 1977 - Auditorium Rossanna Hall

9:00 a.m. - 9:10 a.m. Opening of the Conference
, Black Student Caucus

9:10 a.m - 9:20 a.m. Welcoming Remarks
Dr. Bernard [illegible]

9:20 a.m - 10:00 a.m Introduction of Agenda
Speaker: [illegible]
Student Union Board

3

Mr. Floyd McKissick, J.D.

10:00 a.m - 10:15 a.m Break

10:15 a.m - 12:15 p.m. Panel: "Black Involvement in Health Policy"

Moderator: Dr. Donald Easley

Panelists:

Wilhon Montgomery, Ph.D.
Clay Simpson, Ph.D.
E. Lavonne Allison, Ph.D

12:15pm. - 1:30 p.m. Lunch

1:30pm. - 5:30 p.m. Panel: "Institutional and Attitudinal Barriers to Health Care"

Moderator: Jenkins
Panelists:

Audrey Johnson, D.S.W
Ruth Dennis Ph.D
William Purdy, M.D

7:00 Social
Cash Bar

Thursday - March 31, 1977 - Auditorium, Rossanna Hall

9:30 a.m - 11:30 a.m Panel: Rural Health Perspectives

Moderator: Kubal Ashy

Panelists:

John Hotch, Ph.D.
C. Arden [illegible], M.D
H. [illegible] Berger, M.D

8

11:30 am - 1:00 p.m. Lunch

4

1:00 p.m - 3:00 p.m. Panel: Independent Health Perspectives

Moderator: Jeanne Jones

Panelists:

Glenn Rouse, Ph.D
Jim Lee Ph.D
E. Siegel M.D

3:00 pm. - 3:30 pm Concluding Remarks:
Black Student Caucus

3:30 pm - Conference Adjournment

Black Health To Be Discussed

Durham Sun 3/2-3/77

CHAPEL HILL — The health of black populations will be examined tomorrow and Thursday at a free public forum sponsored by the University of North Carolina at Chapel Hill school of public health and its black student caucus and student union board.

Lawyer Floyd McKissick, president of Soul City Co., will be the keynote speaker. His address, "Health, Politics and Economics" will begin at 9 a.m. tomorrow.

All sessions will be held in the auditorium of Rosenau Hall at the school of public health.

Registration is not required for the two-day program.

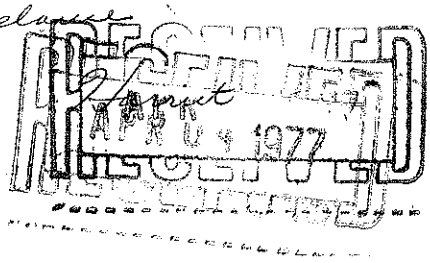
Four panels will discuss various aspects of black health care: black involvement in health policy, institutional and attitudinal barriers and rural attitudinal barriers and rural and international health. Topics include how the federal government is addressing the issue of equity in manpower, impact of racism, role of folk medicine and blacks as objects of experimentation.

In addition to UNC faculty members, panelists include William Darity, dean, school of public health, University of Massachusetts, Amherst; Ruth Dennis, professor of psychiatry at Meharry Medical College; and Clay Simpson of the U.S. Department of Health, Education and Welfare.

3/31/77

Bill:

Attached is the story about the conference in the Durham Sun. I thought the conference was a huge success and think everyone who helped with the planning should have a round of applause.



3/27/77

Bill Small.

Bill:

Attached is a copy of the news article which was sent out from the News Bureau as soon as you gave me the information.

The papers themselves determine whether they will give advance publicity or concentrate articles while the conference is in progress.

It would be good to share McKissick's speech with them as soon as we can get a copy.

Harriet

News Bureau
THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

302 BYNUM HALL-008-A CHAPEL HILL, N.C. 27514 (919) 933-2091

3/17/77 (Ann Paylor)

(285)

FOR RELEASE AT WILL THROUGH MARCH 29

HEALTH OF BLACK POPULATIONS EXAMINED MARCH 30-31 AT UNC-CH

NOTE TO EDITOR: Program enclosed

CHAPEL HILL -- "Perspectives on the Health of Black Populations" is the theme of a March 30-31 forum at the University of North Carolina at Chapel Hill.

Sponsored by the black student caucus and the student union board of the UNC-CH School of Public Health, the free, public forum will open at 9 a.m. Wednesday (March 30) with an address by lawyer Floyd McKissick, president of Soul City Company. He will discuss "Health, Politics and Economics."

The forum will be held in Rosenau Hall.

Various aspects of the health of black populations will be explored in four panel discussions on black involvement, barriers, and rural and international health. Topics to be probed include "The Impact of Racism," "Blacks as Objects of Experimentation" and "The Role of Folk Medicine."

Besides faculty from UNC-CH, speakers will come from the Pennsylvania Department of Health, Meharry Medical College, University of Massachusetts at Amherst and State University of New York at Stony Brook.

No registration is required. For further information, contact William T. Small, assistant dean, School of Public Health 201H, UNC, Chapel Hill, N.C. 27514.

###

'ty founder speaks at forum

Kissick: health discrimination continues

RANSBOTTOM
ff Writer

health simply and put
l separate it from the
Floyd McKissick said
keynote address to a
convention. "Health
is politics, and health
a bureaucracy."
ident of the SoulCity
of Soul City, spoke to
00 persons at the
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ons," sponsored by the
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the School of Public

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c said, and he pointed
classic example of this

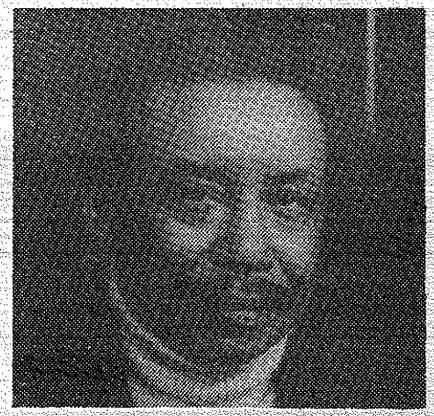
ng 50 people a day in
and just trying to put
nanent building and
vices, giving health
population. And what prevents health services? It became a political decision."

McKissick said that not only health, but all areas of life are controlled by politics and economics and that blacks need to become more sophisticated than they were in the 1960s to survive in this type of society.

"It's just like in the government when it comes to getting money from the SBA (Small Business Administration); you must be declared to be socially or economically deprived. And black folk got to go in there and prove that.

"All we had to do (in the '60s) was have a strong commitment, a sense of organization and a willingness to endure pain and humiliation because we were then dealing with the problem of racism as a moral problem rather than as an economic problem."

McKissick termed this new kind of racism "institutional racism", and he said that as long as racism exists, society will never be truly integrated, and minorities will remain at the bottom of the social ladder.



All the time that the civil rights movement was in progress, McKissick said, "The other part of society has slowly elevated itself upward and upward; and while we were working for a 1932 Ford, the standard now is a Rolls Royce and a Mercedes.

"The struggle of the '60s for integration has not yet been won...Health is one of many facets that we must concentrate on."

—Floyd McKissick

"You got to the Ford level—and that's basically where we are today. The struggle of the '60s for integration ha not yet been won. If you think that struggle is over with, then go psychiatrist. Health is one of facets that we must concentrate

Black Populations' Health Examined Here

The health of black populations will be examined here Wednesday and Thursday at a free, public forum sponsored by the University School of Public Health and its black student caucus and student union board.

Lawyer Floyd McKissick, president of Soul City Company, will be the keynote speaker. His address "Health, Politics and Economics" will begin at 9 a.m. Wednesday.

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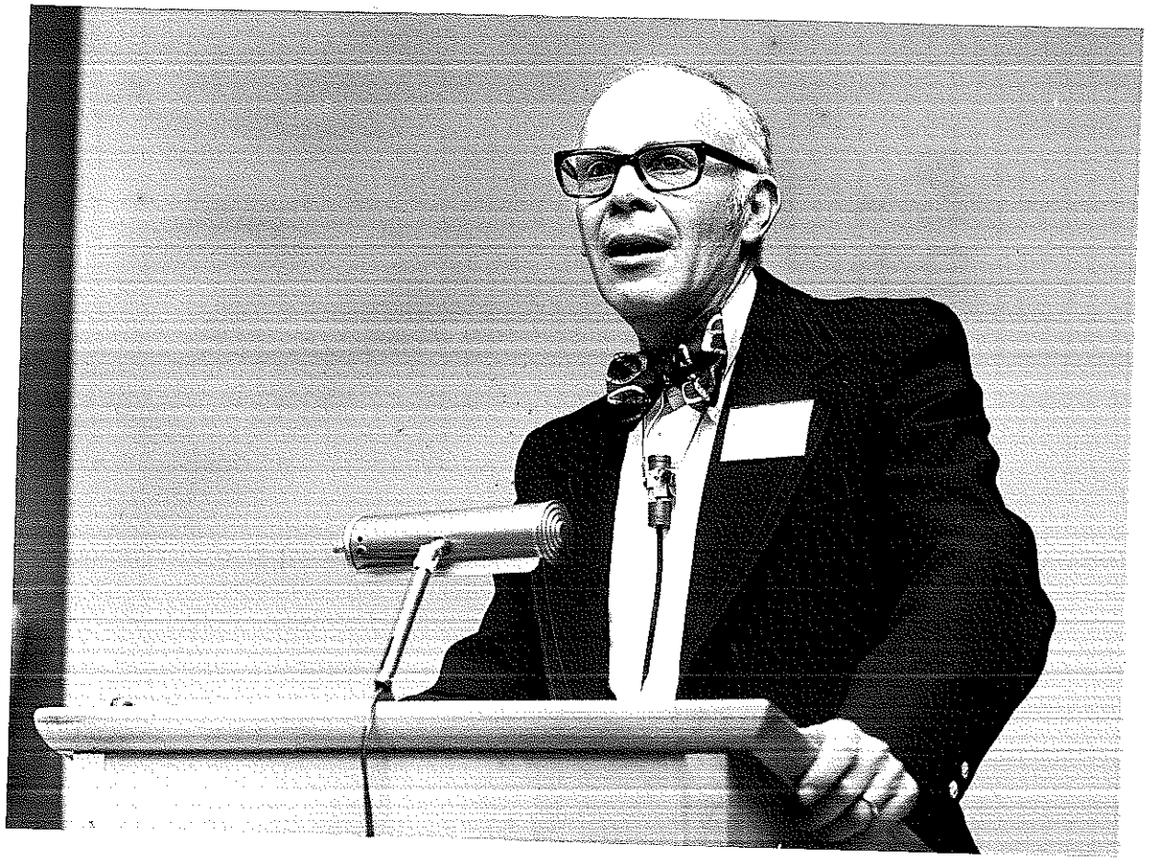
Registration is not required for the two-day program.

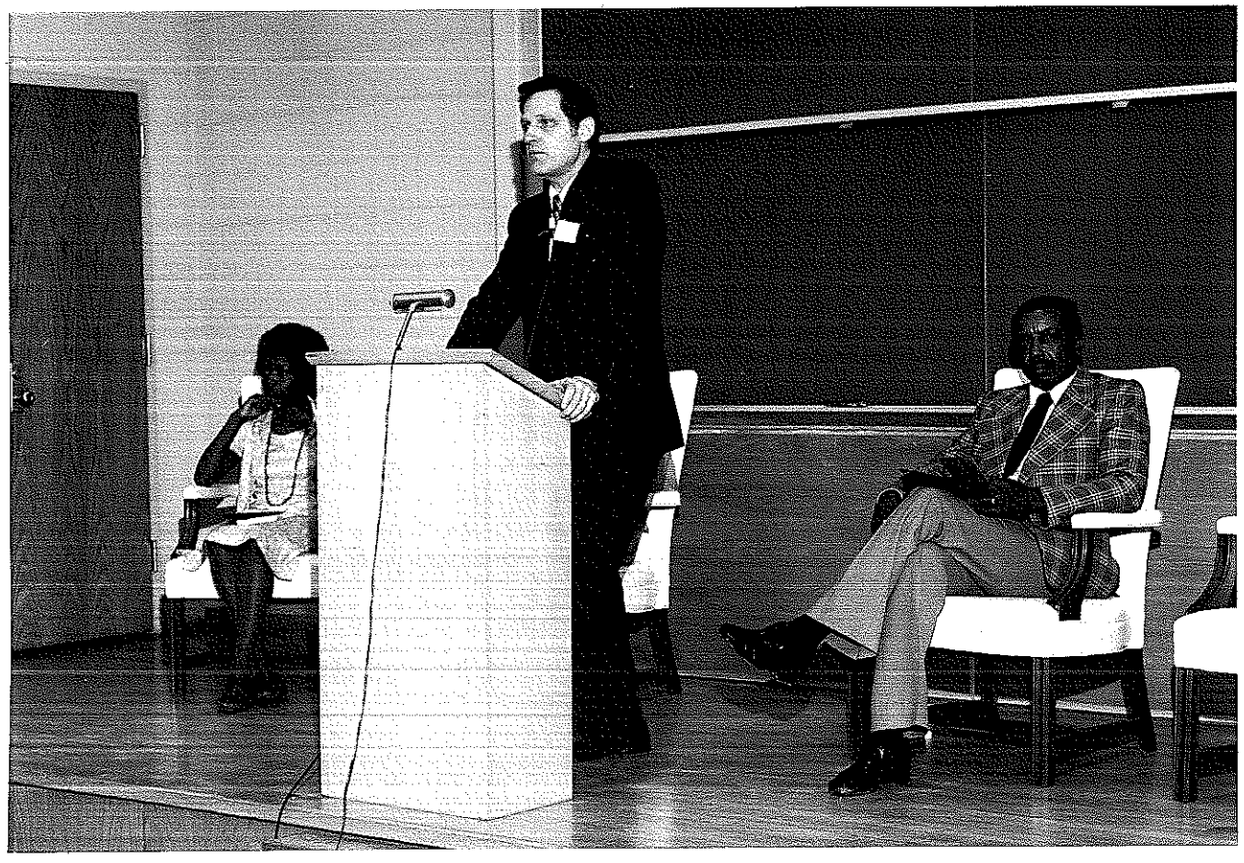
Four panels will discuss various aspects of black health care: black involvement in health policy, institutional and attitudinal barriers, and rural and international health. Topics include how the federal government is addressing the issue of equity in manpower, impact of racism, role of folk medicine and blacks as objects of experimentation.

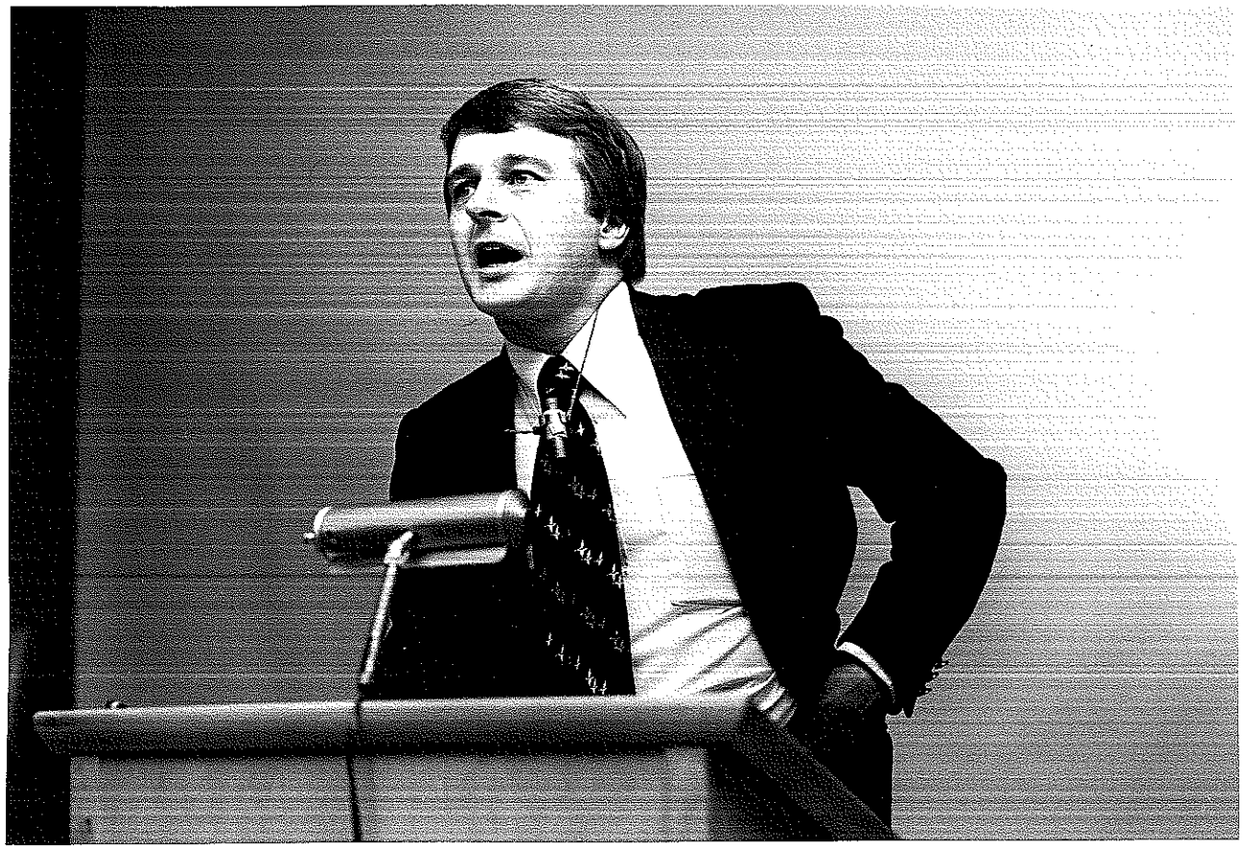
In addition to UNC faculty members, panelists include William Dariety, dean, School of Public Health, University of Massachusetts, Amherst; Ruth Dennis, professor of psychiatry at Meharry Medical College; and Clay Simpson of the U. S. department of health, education and welfare.

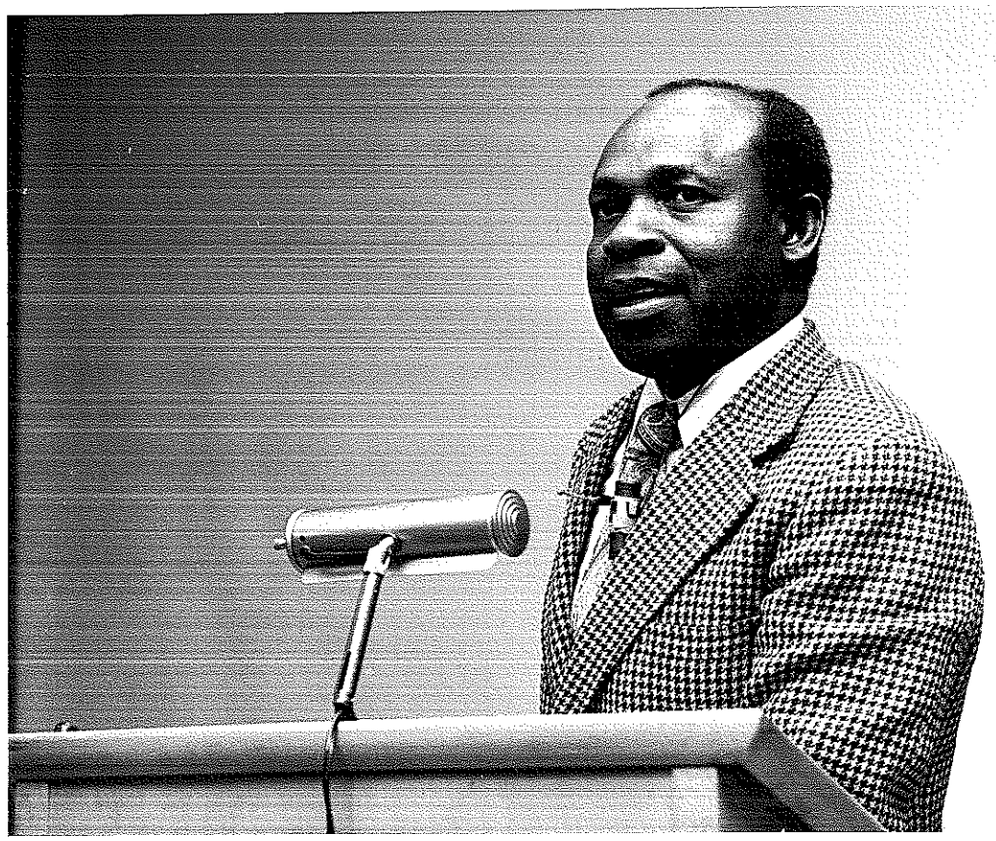
McKissick

Durham Morning Herald









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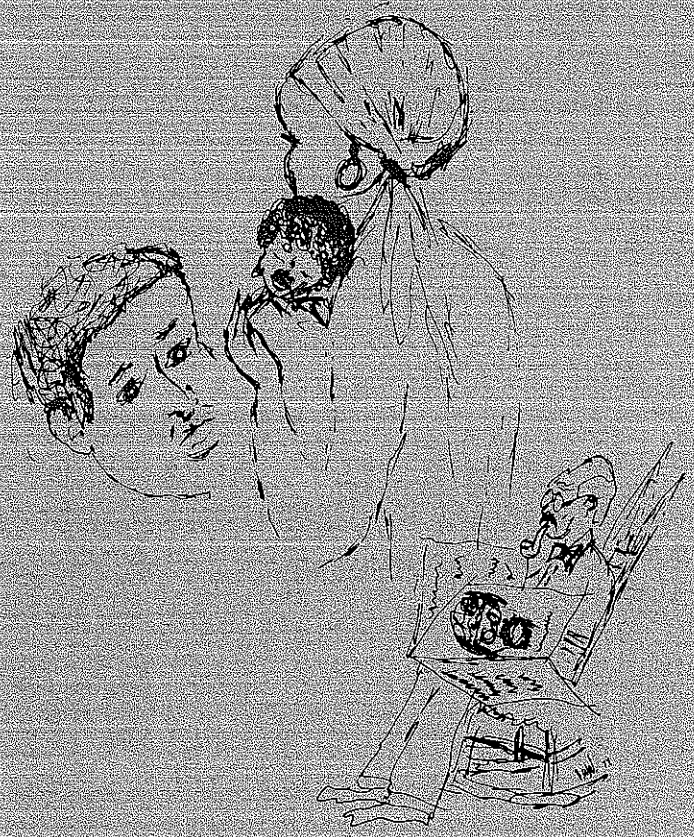
Co-sponsored by the Black Student Caucus and the Student Union of the School of Public Health at the University of North Carolina at Chapel Hill.

Perspectives On The Health Of Black Populations



March 30 and 31, 1977

ck Student Caucus and the Student Union
he School of Public Health of the Universi-
Carolina at Chapel Hill are presenting the
at we hope will be a series of conferences
on the unique and special concerns of
opulations.

me of this year's conference is "Perspec-
e Health of Black Populations." We feel
ubject areas chosen for the focus of this
e are of special concern for public health
als who will be working with black people
ationale in the selection of these areas is
l sufficient attention has not been given in
s in the School of Public Health.

WEDNESDAY, MARCH 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Bernard G. Greenberg, Ph.D., Dean
Introduction of Program
Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker
Fred Levick, President, Student Union

Keynote Address
Health, Politics and Economics
Mr. Floyd McKissick, J.D.

10:00 a.m. Break

10:15 a.m. Panel Discussion - *Black Involvement in Health Policy*

Donald Ensley, Ph.D., Moderator

Public Health Practices and Minorities
William Montgomery, Ph.D.

"How the Federal government is addressing issues of equity in manpower"
Clay Simpson, Ph.D.

Black Manpower in the Health Field
E. Lavonia Allison, Ph.D.

12:30 p.m. Lunch

2:00 p.m. Panel Discussion
Institutional & Attitudinal Barriers in Health Care
Cynthia Jenkins, MSW, Moderator

The Impact of Racism
Audreye E. Johnson, D.S.W.

The Role of Folk Medicine
Ruth Dennis, Ph.D.

Blacks as Objects of Experimentation
William Darity, Ph.D.

4:45 p.m. Social Hour - Student Lounge, School of Public Health

THURSDAY, MARCH 31, 1977

Auditorium - Rosenau Hall

10:00 a.m. Panel Discussion:
Rural Health Perspectives
Robert Kelly, MPA, MPH, Moderator

Panelists:
John Hatch, Ph.D.

C. Arden Miller, M.D.

H. Jack Geiger, M.D.

12:00 p.m. Lunch

2:00 p.m. Panel Discussion:
International Health Perspectives
Jeanne Jones, MSW, Moderator

Nutritional Aspects
Joseph Edozien, M.D., Ph.D.

African Perspectives
Glenn Roane, Ph.D.

Jim Lea, Ph.D.

Carribean Perspectives

Conference Participants

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Director
North Carolina Health Manpower Corp.
NCNB Bldg., Chapel Hill, N.C.

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Ruth Dennis, Ph.D.
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PERSPECTIVES IN HEALTH CARE OF BLACK POPULATIONS

March 30 & 31, 1977

ROSENAU HALL AUDITORIUM
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

DISCUSSION TOPICS:

HEALTH POLICY
Wednesday, March 30, 9:00 a.m.

BARRIERS TO CARE
Wednesday, March 30, 2:00 p.m.

RURAL HEALTH
Thursday, March 31, 10:00 p.m.

INTERNATIONAL HEALTH
Thursday, March 31, 2:00 p.m.

SPONSORED BY:
THE BLACK STUDENT CAUCUS AND THE STUDENT UNION BOARD
SCHOOL OF PUBLIC HEALTH

FOR FURTHER INFORMATION PLEASE CONTACT: WILLIAM T. SMALL
ASSISTANT DEAN
SCHOOL OF PUBLIC HEALTH
919-966-1113

FORUM

Perspectives On The Health Of Black Populations

March 30 and 31, 1977

Co-sponsored by the Black Student Caucus and the
Student Union Board of the School Of Public Health
Of the University of North Carolina at Chapel Hill

PROGRAM

Wednesday, March 30, 1977

9:00 a.m. Opening Session - Auditorium, Rosenau Hall

Welcome - Dr. Bernard G. Greenberg, Dean
Introduction of Program - Doris Magwood, Chairperson
Black Student Caucus
Introduction of Speaker - Fred Levick, President
Student Union

Keynote Address "Health Politics and Economics"
Mr. Floyd McKissick, J.D.
President, Soul City Company
Soul City, N.C.

10:00 a.m. Break

10:15 a.m. Panel Discussion - Black Involvement in Health Policy

Moderator - Donald Ensley, Ph.D., Assoc. Professor, Dept. of Community Health,
East Carolina University
Public Health Practices and Minorities - William Montgomery, Ph.D.
Deputy Secretary for Health Systems
Development, Pa. Dept. of Health

Issues of Equity in Manpower - Clay Simpson, Ph.D.
Associate Administrator for Health Resources
Opportunity Programs, Health Resources Admin.
Public Health Service, DHEW

Black Manpower in the Health Field - E. Lavonia Allison, Ph.D., Director
North Carolina Health Manpower Corp.

12:30 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - Institutional & Attitudinal Barriers In Health Care

Moderator - Cynthia Jenkins, Doctoral Student in Maternal and Child Health,
Univ. of N.C.
The Impact of Racism - Audreye E. Johnson, D.S.W., Associate Professor
School of Soc. Work, Univ. of N.C.

The Role of Folk Medicine - Ruth Dennis, Ph.D., Professor
Dept. of Psychiatry, Meharry Medical College

Blacks as Objects of Experimentation - William Darity, Ph.D., Dean
School of Public Health
Univ. of Mass. at Amherst

4:45 p.m. Social Hour - Student Lounge, School of Public Health

TENTATIVE PROGRAM

Thursday, March 31, 1977

Auditorium - Rosenau Hall

10:00 p.m. Panel Discussion - Rural Health Perspectives

Moderator - Robert Kelley, Doctoral Student in Health Administration, Univ. of N.C.

Panelists - John Hatch, Ph.D., Associate Professor
Dept. of Health Education
School of Public Health, Univ. of N.C.

C. Arden Miller, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

H. Jack Geiger, M.D., Professor & Chairman
Dept. of Community Medicine
State University of New York at Stony Brook

12:00 p.m. Lunch (on an individual basis)

2:00 p.m. Panel Discussion - International Health Perspectives

Moderator - Jeane Jones, Doctoral Student in Health Administration, Univ. of N.C.

Nutritional Aspects - Joseph Edozien, M.D., Ph.D., Chairman
Dept. of Nutrition
School of Public Health, Univ. of N.C.

African Perspectives - Glenn Roane, J.D.
Former Director of Regional Population Office for Africa U.S. Agency for International Development
Washington, D.C.

Jim Lea, Ph.D., Director
African Health Training Institutes Project
Carolina Population Center, Univ. of N.C.

Carribean Perspectives - Earl Siegel, M.D., Professor
Dept. of Maternal and Child Health
School of Public Health, Univ. of N.C.

4:30 p.m. Adjourn

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL
27514

SCHOOL OF PUBLIC HEALTH
OFFICE OF THE DEAN

TELEPHONE
AREA 919 966-1113

March 3, 1977

Dear Colleague:

A great event will take place at the University of North Carolina at Chapel Hill on March 30-31, 1977: The Black Student Caucus and the Student Union Board of the School of Public Health are co-sponsoring a conference centered around the theme "Perspectives on the Health of Black Populations" (see enclosed tentative program).

We invite you to attend and participate in the various aspects of the program. There is no conference fee for this event, however, you will be personally responsible for your lodging and subsistence.

Accommodations may be arranged through the following motels in Chapel Hill: The Carolina Inn (on the UNC Campus), single $10-$16, double $13-$21, phone: (919) 933-2001; The Holiday Inn, U.S. 15-501 Bypass, single - $16-$17, double $20-$22, phone: (919) 929-2171; and the University Inn , East of U.S. 15 and N.C. 54, single $10-$14, double $14-$18.50, phone: (919) 942-4132.

Please do not hesitate to let me know if I can be of assistance in any way. You may call me at (919) 966-1113.

Sincerely,

William T. Small
Assistant Dean

WTS:gj

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

27514

SCHOOL OF PUBLIC HEALTH
OFFICE OF THE DEAN

TELEPHONE
AREA 919, 966-1113

March 8, 1977

Dear

On March 30-31, 1977, the Black Student Caucus and the Student Union Board of the School of Public Health are co-sponsoring a conference centered around the theme: "Perspectives on the Health of Black Populations" (see enclosed tentative program).

We invite you to attend and participate in the various aspects of the program. There is no conference fee for this event, however, you will be personally responsible for your lodging and subsistence.

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