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The Status of Student Health Programs in Negro Colleges, 1938-39

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PROGRESS has been made in the health status of the Negro in the United States, but this has been little when contrasted with that made by the white population and evaluated in the light of the extent, magnitude, and variety of his health problems. A consideration of a few random statistics is all that is necessary to support this oft-repeated statement.

The mortality rate of the Negro at present is from 30 to 40 per cent higher than that of the white population. The most pronounced differences, however, are found in the ages between 15 and 25 years. At this level, the death rate for colored boys and young men is nearly two and a half times that for the whites, and the rate among young colored women is more than three times that for young white girls.^{1*} Progress in the reduction of this mortality has been very slow. In a recent study by Gover,² in which the general mortality rates for white and colored groups are compared for the periods 1921-24 and 1931-33 in ten southern and northern states, it is shown that these rates have decreased 2.5 per cent for the colored and 7.7 per cent for the white population.

This higher mortality necessarily shows itself in a lower expectation of life. A white baby born today may expect to live 65.2 years if it is a female, and 61.5 if a male.³ Contrasted with this, we find that the latest reliable figures show the expectation of life for the Negro newborn to be 47.5 and 49.5 for male and female respectively. What is most startling, however, is the fact that since 1920 the Negro male between 20 and 50 years of age has lost on the average of three years in his expectation of life at every age.⁴ This same loss holds true for the Negro female. The white group, on the other hand, has also lost in this age period, but this has been less than one year at any age period.

When we turn our attention to mortalities from specific causes, we are confronted with the same inequalities and snail-paced progress. The captains of death in the Negro population are heart disease, tuberculosis, pneumonia, syphilis and gonorrhoea, and diseases of maternity and infancy. The death rates of these major conditions when compared with those of the white group show a disproportion in many instances of as

A paper presented at the First State Conference of College Health Workers in Negro Institutions, June 20-21, 1940, Orangeburg, South Carolina.

* Superior figures refer to numbered Bibliography at end of article.

high as ten to one. Tuberculosis, for example, is considered the seventh cause of death in the United States; yet in most Negro communities, it is the first or second on the list. The greatest disparity between the two groups for this disease is found in the younger years. Among the female group in the ages from 10 to 14, the ratio of colored to white is 8.6 to 1, while in the male between 15 and 19, it is 7.1 to 1. Here, again, it is seen that the young Negro adolescent is at a great disadvantage.

Syphilis, "The Great Killer," is another example. Parran⁶ has often said that in this country approximately six times as many Negroes have this disease as white individuals. Many Wasserman surveys throughout the South have demonstrated a prevalence ranging from 9 per cent in Albermarle County, Virginia, to 39 per cent in Macon County, Alabama.⁷ Findings of the recent premarital examination requirements instituted in many states show this disproportion. In the city of New York, during the first six months of the enactment of the law, of the total white applicants examined, .61 per cent were positive as compared to 9.8 per cent for the Negroes tested.⁸ Even the comparison of college groups demonstrate these inequalities. In a study by Tumbleson and Ennes,⁹ it was found that reports on 2313 blood tests given in 11 Negro institutions showed positive reactions in 26.8 cases per 1000 individuals as compared to 1.99 per 1000 in 78,388 tests given to students in 516 white colleges. Here again, it must be emphasized that the venereal diseases have their highest attack rate in young adults between the years of 16 and 30.

Endlessly this presentation could be unfolded and the ultimate and inescapable conclusion would be that the health of this one-tenth of the nation, particularly of that group made up of adolescents and young adults, needs to be markedly improved.

What then are the causes for these glaring inequalities? The answer which has been repeatedly stated consists of three parts. First, throughout this country there is a dire need for facilities and sufficient competent health personnel to give adequate services to Negroes. Secondly, the low socio-economic status of this minority group contributes markedly to its unfavorable health situation. Finally, the paucity of effective health education in this group plays an important part in its mortality and morbidity experience.

Of these three contributing factors, the last appears to be of greatest import particularly as it applies to a small yet very important segment of the Negro population—the 40,000 college students in Negro institutions of higher learning. It has been said that approximately 6 per cent of the population of the United States have attended college and 2.4 per cent are college graduates; yet 50 per cent of the positions of influence and leadership in the life of the people are occupied by college men and women.¹⁰ If this also be true for the Negro population, then it may be assumed that the proper nurture in health education of these

young people who spend from four to six years of their lives within cloisters of learning should produce leaders with the proper health perspective, ideals, attitudes and visions, who will be able to formulate, mould, and direct public opinion on health matters. It seems to us that the achievement of the other two goals, namely, better health services and improvement of the socio-economic level, must depend heavily on the effective health education of this segment. The Negro youth who will eventually be a teacher in a one-room school in Summerville, South Carolina, or a clinic physician in a large plantation on the Mississippi Delta, or a minister in the Piney Woods of Georgia, if he has been thoroughly imbued with health knowledge and has been taught full appreciation for good health habits, attitudes, ideals, and good community health, will certainly work diligently for more well-equipped and approved hospitals, more and better trained physicians, nurses, and dentists, improvement of maternal and child welfare programs, healthier working facilities for his brother in industry, and bigger budgetary allowances for health departments in his community.

What then are Negro colleges doing to meet this responsibility? It is well therefore for us to turn our attention to a consideration of the present status of student health activities in Negro colleges. In order to have an answer to this query and also to stimulate the development of student health activities in Negro colleges, the National Tuberculosis Association in December, 1936, and subsequently the American Social Hygiene Association in 1938, began making annual grants to Howard University. We set as our primary task the investigation by personal inspections of a representative sample of Negro colleges, and so in the school year 1938-39, 51 Negro institutions scattered in 15 states were personally visited in order to study their health programs and inspect their facilities. The discussion which follows is based on the analysis of the reports of these 51 schools.

ORGANIZATION

It has been repeatedly stated that the organization plan which comes nearest to insuring the development of an adequate health program is the one wherein the various divisions engaged in health work are grouped under a single administration. This plan as stated by Diehl¹¹ "centralizes responsibility for the health program in one individual, and if the head or director of this unit is a competent executive and a man of vision, a satisfactory coordination of activities and complete health program is almost certain to be developed, and numerous economies of effort and of funds should result."

This pattern is not commonly followed in Negro institutions. Of the 51 schools investigated, only 13 had a single department in charge of health and physical education. The most common administrative practice in these institutions is that of two separate divisions, generally with very little coordination between the two, with one in charge of

physical education and hygiene, and the other concerned only with the medical supervision of the student body. Furthermore, in such an organization, it is found that as a rule the former has full academic status while the other has not. This situation would be passable if there were in these schools with separate divisions, faculty health committees which would coordinate these activities and integrate other departments into a comprehensive health program. Only approximately 25 per cent of the schools visited have a faculty health committee, and in only a very small number of these were these bodies functioning, alert, and serviceable groups, rather than paper organizations. From this brief consideration, it is seen that presidents of Negro institutions will have to turn their attention to the development of better administrative units if they hope to achieve the greatest good.

HEALTH SERVICES

The student health service is admittedly an important phase of the college health program. The entrance health examination, defense against quackery, good personal habits, appreciation of good medical services, and the early treatment of incipient and minor illnesses are generally instilled into the student by association with a well-organized health service.

The 51 schools employed, in 1938-39, 47 part-time physicians, 2 part-time and 19 full-time nurses. It is immediately apparent that there is need for an increase in personnel in order to meet the accepted standard of student health practice. The acuteness of the situation is emphasized when the facts are scrutinized more closely. Eight of the 51 institutions have neither a physician nor a nurse to take care of student illnesses and health problems. In only one of the institutions with an enrollment of 500 or more students was a full-time physician employed. The outlook becomes even darker when the availability of medical consultation on the campus is considered. Only in a little over half of the schools visited does the physician spend any time on the campus so as to be able to see ambulatory students who are ill, or to hold follow-up conferences. In other words, the schools which state that they employ a part-time physician all too often mean that he is employed only to perform the entrance health examinations.

The school which assumes the responsibility of the health care of its student body must provide facilities for rendering it. This is just as important as providing laboratory and space equipment for the chemistry department. A good health service should have a dispensary where examinations, consultations, follow-up and minor treatments are given; an infirmary facility where students with minor illnesses may be admitted for a short period of time; and hospital connections, either official or semi-official, where individuals with more serious illnesses may be confined. Ideally, the dispensary and infirmary with a certain amount of necessary equipment should be centralized in one unit with

provision for toilet and lavatory facilities, and rooms for isolating students with communicable diseases.

There is need for such units in Negro schools since many of them have dormitories which are quite often overcrowded and wherein, in many instances, two or even three students share the same bed. In addition, many are located in southern communities where hospital and medical facilities are sadly lacking. However, investigation of this phase of the program shows certain inadequacies. Of the 51 schools, only half had dispensary units, a third had men's infirmaries, and only eight of the total number were affiliated with or had hospitals of their own. The availability of dispensary and infirmary care in the small schools is very meager, but this is just a graver expression of the situation which exists in the larger schools.

The equipment of the dispensaries and infirmaries leaves much to be desired. In one school, this consisted solely of a room with table and cabinet, and with floor area so small that students have to remain standing while the physician is giving treatment or advice. In another, the school physician ministered and advised students in a room adjoining the gymnasium with not even a pair of scales to weigh students. This also was true of many of the infirmaries inspected. Outside of beds, little or no equipment was found in them.

HEALTH FEE

It is an accepted fact that the individual health fee should be the largest contributing source of income for financing student health work. This, however, does not appear to be the case in Negro schools. In a little over half of them is a health fee charged. Of these 27 institutions, 18 charge less than \$4. This is lower than the usual fees of either \$5 or \$10 assessed in white schools. Thus, it may be seen that health fees do not contribute much to the financial support of health services in Negro institutions. The reasons for this situation may be explained on the basis that Negro students on the average are poor, and therefore, an attempt is made by administrators to have the tuition and other fees as low as possible so that student enrollments will not in any way be curtailed.

Thus, many of the deficiencies which are set forth in this paper are in part functions of the budgetary allowances which are made for the health and medical care of students.

HEALTH EXAMINATIONS

The health examination is possibly the most important procedure in the college health program. Through this medium, both the individual student and the university community are protected. By the discovery of physical handicaps, preclinical conditions, and poor hygienic habits the individual may be advised and much future physical damage may be avoided, while through the discovery of communicable diseases,

such as tuberculosis, syphilis, gonorrhoea, and athlete's foot, widespread involvement of the student body is prevented.

The present study shows that 39, or 80 per cent, of the schools offer certain types of health examinations to their student bodies. The schools which are most delinquent in this phase of the program are those belonging to the class with an enrollment of less than 300 students since here it is found that almost half do not offer health examinations. The majority of the 39 schools complete the examination of the student during the first four weeks of the school year. The desired ideal of performing this before the beginning of the school session is achieved in only three of these schools. Interestingly enough, when these institutions are divided according to groups of students who are the recipient of the examination, it is found that the colleges are equally divided into those which examine all of the students yearly and those which limit this activity to new entering students alone. As a general rule, it may be said that when all the students are examined yearly, this is poorly done and has very little value.

The health examination in order to be of value should be thorough and in the opinion of the writer should include the following five basic procedures; namely, the tuberculin test, X-ray of positive reactors, blood examination for syphilis, urine analysis, and the examination of the eyes for visual acuity, this latter being of particular importance at this level. In only one of the 38 schools for which complete information is at hand are all of the basic procedures included in the health examination, while in 18 per cent none of these items is part of the health appraisal. About an equal number of schools include one, two, or three of these measures. It is of interest to note that the procedure most frequently included is the blood examination.

In addition to these glaring omissions of basic procedures, it is found that the physical examination itself in almost 50 per cent of the schools is of poor quality. After observing various record forms and talking with physicians in charge of these activities, one is impressed with the superficiality of these performances. In many instances, the medical history is lacking. In too many, the examination is only an inspection and in several schools, the blood pressure is not even taken. One wonders why physicians presumably with scientific training will yearly carry out such face-saving procedures. Admittedly, they receive very small compensations for their services, and therefore cannot devote much time and energy to the work; yet in many instances, it appears that with better organization, much more could be accomplished.

RECORDS

Since the student spends from two to four years in college, it is the responsibility of the school to keep a complete health record of every individual so that each illness may be understood in the light of previous ailments and every contact with the health service will

be recorded. Health authorities are also of the opinion that "a unit record system" whereby all information pertaining to the health of each student, kept in individual folders or envelopes, should be used. Negro institutions, as may be surmised, keep few records, and these as a rule are poorly kept. Of the 34 schools which had forms, about 70 per cent keep only one; namely, the physical examination schedule. Twenty per cent of these used 2, and only 10 per cent had reached the high mark of 3 forms. Consultation, infirmary, parent notification, and other records are sadly lacking. In many schools, consultations are noted, but these are written chronologically day by day in a notebook. In some, even this is not done, and only the medicines dispensed without names or reasons for giving them are recorded. Unit record systems are not the mode in these institutions since only 4 of the 34 schools had adopted this practice in 1938-39.

HEALTH INSTRUCTION

Preparation for full and happy living has been one of the more important trends in modern education. Thus, it has been emphasized that health teaching should be an integral part in the curriculum of every college and university. This study shows that there is need for better organization and greater emphasis on health instruction in Negro schools. One finds no unanimity of opinion as to what department shall have charge of this important responsibility. In 52 per cent of the schools, this was placed either in the department of health and physical education, or physical education; in 30 per cent, it shifts yearly from one department to another; and in 12 per cent, the physician or nurse, without relationship to any academic department, has charge of the hygiene teaching. In this connection, it may be stated that in the majority of the colleges the physician takes very little interest or active part in the formal teaching of health courses.

Health instruction, like all other educational processes, to be effective should be so available that there will be opportunities for repeated exposures. In 1938, only 80 per cent of the schools offered health courses. Of these, 45 per cent offered only one course, 35 per cent had two, and the rest, or 20 per cent, offered three or more courses. Although admittedly this is not a bad showing when compared to white schools of comparable enrollment, yet there is room for improvement in this phase of the program.

Of particular significance in this discussion is the availability of required health courses in the curriculum of these institutions. It was the consensus of opinion at the Second National Conference of College Hygiene that there should be in all institutions a required credit course in hygiene of not less than two semester hours. Of the 51 schools investigated, in only 15, or about 30 per cent, is a course in health compulsory for first year students. Although the schools with required courses seem to be doing a commendable job, yet it is regrettable that there is such a paucity in the number of colleges with this requirement.

SANITATION

Those who are familiar with methods in public health know that the initial health activities resulting from the early scientific observations were environmental. However, we notice that in Negro colleges and universities this facet of the health education program is woefully neglected at present.

The sanitation of food and the environment in which it is prepared is of primary importance in a university community and may be taken as the first example. In only 7 out of 21 schools were facilities available to food handlers for washing their hands. On questioning, it was found that in the great majority of these institutions no attempt was made to require that all food handlers wash their hands before serving meals. Screening of windows was found in practically 80 per cent of the schools; but even so, flies were present in many kitchens and dining rooms, due either to faulty screens or carelessness in the closing of doors.

The food handler's examination is of some value in this program. Yet, here we find that of 48 schools, only 29, or 60 per cent, required a health examination of their food handlers, but of these, only 11 required that all be examined. The rest were satisfied with the examination of only the student helpers. Why the cook, dietitian, and non-student helpers are not examined in a great number of schools is difficult to explain. The quality of these examinations is not much better than that generally given to the student body as a whole. In many instances, the examination merely consists of physical inspection. In very few schools are throat and stool cultures done when indicated; while the search for tuberculosis by routine flat chest X-ray is seldom included.

Before leaving the subject of food, a word should be said about the status of nutrition in these schools. Although here again the sampling is not large, yet certain deficiencies may be noticed. In only 13 of the 29 institutions could the meals regularly served to the students be considered as well balanced. In a goodly number, the meals were too often lacking in protective foods and consisted of a super-abundance of carbohydrates. The following sample meals from our investigations vividly bring out this point.

Mid-day Meal: Bologna sandwiches and tea

Evening Meal: Creamed potatoes and apple sauce

Mid-day Meal: Beans, cornbread and apple pie

Evening Meal: Bread, salmon croquettes, dressing, spaghetti, and beans

Milk is not freely available. In only 8 of 25 schools was this "most perfect food" served to students three or more times per week. Of interest, also, is the fact that in eight of the schools visited, the milk served was not pasteurized, and quite often, the harvesting of this easily perishable product violated established sanitary principles.

The sanitary conditions of the dormitories is also of special significance. The conditions in the men's units were appalling and in many instances suggested medieval practices. Dirty sheets and pillow cases, dirt and trash in the hallways and rooms, poor plumbing in lavatories and toilets, ill-kept shower rooms are too often found on the men's side of the campus. Women's dormitory rooms are generally much better kept. The reason for this difference is simply one of lack of effective supervision through rigid regular inspections. Where this is equally enforced in both the men's and women's dormitories, such marked differences in the general cleanliness and upkeep do not exist.

Lighting presents a very acute problem in Negro schools. In practically all, the quality and quantity of light are inadequate. In many dormitories, light is obtained only from a central ceiling bulb of low wattage. In many schools, students do not have any desk lamps, and those who possess such have them for adornment rather than for use. In a few institutions students do not have desks and are forced to study sitting on the sides of their beds. In addition in a number of colleges, the practice is still in force whereby all lights except those in the halls are turned off either at 10:00 P.M., 10:30 P.M., or 11:00 P.M., and students desiring to study must do so in the halls. This practice must be condemned as undesirable in a college environment.

Another item which is of concern is the problem of crowded dormitory facilities. In only eleven of the men's and sixteen of the women's dormitory systems were all the rooms occupied by the normal number of two students. On the other hand, in the ten remaining men's and eight women's units for which we have information, one finds in certain sections or even in whole dormitories three and more students sharing rooms meant for two. Of greater concern is the fact that in a number of schools there are rooms where two and even three students sleep on the same bed.

The final factor which further supports the contention that this group of institutions are as yet not aware of their sanitary responsibilities is seen in the fact that of 49 schools for which we have information, only 10 or about 20 per cent make an annual sanitary survey. Thus in many institutions, no attempt is made to determine yearly the condition of dormitories, light, ventilation, heating, campus cleanliness, garbage and sewage disposal, fire traps, hazards in the gymnasium, and the sanitary conditions of eating establishments which are frequented by their students.

SUMMARY AND CONCLUSION

This summarization of the conditions existing in 51 colleges in the school year 1938-39 shows conclusively that certain health activities are lacking in the majority of these institutions and that the reasons for these deficiencies may be summed up as follows:

1. Lack of interest on the part of college administrators.
2. Lack of sufficient budgetary allowances.
3. Lack of trained personnel.
4. Lack of effective organization.

The apparent lethargy of many presidents and administrative officers in matters relating to the improvement of the hygiene teaching, medical supervision of the student and the sanitation of the environment is the primary obstacle which must be overcome. College presidents must come to the realization that educating the student to meet certain requirements for a degree or certificate also carries with it the responsibility that the student will live in as healthy and clean environment as possible, that he will have a good measure of health protection, and that he will have an opportunity to improve his health habits and attitudes. The school is a community institution. Whether governmental or privately supported, funds are derived from the community. For such an investment, the community demands that when a student again returns to it after a period of four, five or six years, he should be an asset of the highest order. He who graduates with tuberculosis and has transmitted it to three or four student contacts in the college; or the individual with syphilis who has not been discovered, or the one who because of faulty habits and attitudes will later develop a serious degenerative disease and die prematurely is not a good investment. The college administrator who fails to meet this responsibility is not fully discharging his trust to the community.

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