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Trends In Public Health Among Negroes In 96 Southern Counties During The Period 1930-1939

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Trends in Public Health Activities among Negroes in 96 Southern Counties During the Period 1930-1939

II. Comparison of Certain Health Services Available for Negroes and White Persons

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THE Julius Rosenwald Fund in the summer of 1940 made available a grant to the College of Medicine of Howard University for a 3 months' study of the trend in public health activities in relation to the Negro in the United States, which had taken place during the decade 1930–1939. In formulating the protocol for this investigation, an inquiry into the health situation among Negroes in the rural South was given a prominent place, since the Negro health problem, if there be such, is to be found primarily in the rural South. Therefore, letters and questionnaires were sent to 385 southern counties having full-time health units. The schedules requested information along these lines: first, Negro professional personnel employed; second, availability of certain health services according to race; and third, the personal reactions of the administrators of these health units to certain questions of opinion.

The analysis of the first of these three areas of investigations has already been published.[1] The present article is concerned with the second phase; namely, the trends in the availability of certain health services for Negroes as compared with whites during the decade 1930–1939. The last of these analyses will be the subject of a subsequent paper. For a fuller discussion of the characteristics of the 96 counties studied, the reader is referred to the first article, since only one or two pertinent items which will serve to orient him will be mentioned here.

One hundred and seventeen, or 30.4 per cent, of 385 counties responded. However, of this number, 21 had to be discarded for failure to answer the questionnaire. Thus 96 counties, or 24.9 per cent, provided us with schedules which in part or as a whole could be used in this report. The distribution of these counties according to state is shown in Table 1. It is noted that Alabama had the largest representation of counties, with 24, followed by Florida, Louisiana, and Tennessee, with 10 each. Texas, Arkansas, and West Virginia are the only states not represented. Three counties responded from Texas but were not included because of the inadequacy of the information recorded. No questionnaires were received from Arkansas, while West Virginia was not circularized because of the small Negro population, which comprises only 8 per cent of the total in the state.

TABLE 1

Distribution of 96 Counties According to States

State	No. of Counties Responding
Alabama	24
Florida	7
Georgia	10
Kentucky	6
Louisiana	10
Maryland	6
Mississippi	5
North Carolina	7
Oklahoma	1
South Carolina	6
Virginia	4
Tennessee	10
Total	96

The 96 counties had a total of 3,765,183 population, of whom 1,371,572, or 36 per cent, were Negroes. This represents about one-tenth of the whole Negro population and one-seventh of that of the South. Hence, this sample is large enough to be somewhat representative of this section of the South. The population was largely rural, since only 16 of the 96 counties reported city-county organizations. The largest of these combined units was Jefferson County, Ala., which includes Birmingham within its boundary and gives this county a total population of 475,000 individuals, of whom 184,795 are Negroes.

COMPARISON OF CERTAIN HEALTH SERVICES AVAILABLE FOR NEGROES AND WHITE PERSONS

Unfortunately it was impossible to obtain enough information on all of the health activities investigated from a sufficiently large number of counties to be representative at all times of this group. This is due to the fact that for the most part these health units do not tabulate much of their essential data according to color. This is to be regretted because this is one of the methods which help the health officer or any investigator to determine whether or not services are being made available or used according to the needs of particular groups in the population. Even though the limitation of the data must be kept in mind, yet certain trends may be observed. Furthermore, the paucity of material in certain spheres is an excellent argument for urging better collection and tabulation of the data which are daily gathered by health departments.

1. Tuberculosis — Tuberculosis at present is the seventh or eighth cause of death among whites, while it is first or second among Negroes. Therefore services should be developed in a larger measure for Negroes. This, however, does not seem to be the case.

Clinic facilities are an essential part in the tuberculosis case finding program and constitute a bulwark in the first line of defense against the disease. What has been the progress in this direction during the period 1930–1939? Table 2 provides the data for such a discussion. This table is arranged so that it presents in the first two horizontal tabulations a comparison of 17 counties which reported information for

TABLE 2

Availability of Tuberculosis Clinic Hours for Negroes and for White Persons

Year	Counties Reporting	No. of Deaths		Clinic Hours per Week		Clinic Hours per Week per 100 Deaths	
		N	W	N	W	N	W
1930	17	383	217	4.5	11.4	1.2	5.3
1939	17	228	138	15.3	23.9	6.7	17.3
1939	36	390	240	40.3	48.7	10.3	20.3

both 1930 and 1939; while the last horizontal division considers all of the counties which recorded information for 1939, irrespective of whether or not they provided such data for 1930.

It is readily noted when the 17 counties are compared for 1930 and 1939 that in both periods the availability of clinic services for white persons was much greater than for Negroes, although the number of deaths was greater in the latter group. In 1930, Negroes scarcely received 1 clinic hour per week per 100 deaths, while the white population had almost 5. In 1939, the services increased for both groups, although much more for the Negro, so that the disproportion was cut in half, making this 2.5 to 1. Even though there was a growth in this sphere, yet there were a number of counties which still provided no clinic services. In 1930, of the 17 counties, 10 were deficient in this regard, while in 1939, 8, or 50 per cent, still reported this lack. When all of the counties with data for 1939 are considered, the picture changes very little. It is still found that 18, or half of the counties, had no clinic services either for Negro or white individuals. Although this is a relatively small sample, the fact stands out that Negroes are at present receiving less clinic service and there are still many counties without any services whatsoever.

The outlook is not much better when hospital facilities are evaluated. Here again, the condition in 28 counties which reported for both 1930 and 1939 may be studied in Table 3. As would be expected, the number of beds for white persons was greater than for Negroes in both 1930 and 1939. In the former year the 28 counties reported 0.08 beds per death for Negroes as compared to 0.18 for white persons while, in 1939, this had increased for both races, but the disproportion of two to one was still in the Negro's disfavor. Furthermore, neither for the white nor the Negro population was the minimum standard of one bed per death reached. It is also of interest to note that of the 28 counties, 25 in 1930 had beds neither for white persons nor Negroes, while in 1939, the picture had changed very little, so that 20 still reported no hospital facilities. When all of the counties which reported for 1939 are considered, the picture is somewhat more favorable, particularly for white persons, where the minimum of 1 bed per death appears to have been achieved; but for the Negro the situation is still of concern, since less than one-half a bed is available. It is to be noted also that, of the 61 counties, approximately 40, or two-thirds, reported no hospital facilities for either race.

It is beyond contradiction on the one hand to say that progress in tuberculosis control has taken place in the rural areas during the period of 1930–1939 and, measured statistically, this has been a two- to threefold advance. On the other side, however, it must be admitted that, in spite of too meager facilities and services, the tuberculosis deaths in many of these areas have con-

TABLE 3

Availability of Beds for Tuberculosis Care

Year	Counties Reporting	No. of Deaths		No. of Beds		Beds per Death	
		N	W	N	W	N	W
1930	28	517	358	40	60	0.08	0.18
1939	28	376	266	80	129	0.21	0.48
1939	61	682	470	279	547	0.40	1.16

tinued to decrease and that, as a whole, the Negro rates for the South are much lower than those for the North. The causes of this downward trend and this differential are not known, and it might well be of some interest to develop mass surveys in selected rural areas to gain a true insight into the tuberculosis problem among rural Negroes, just as has been done for syphilis.

2. Venereal Diseases — The Negro seems to fare somewhat better in the programs for venereal disease control. Comparing 32 counties in 1930 and 1939 (Table 4), it is found that, on the basis of population, the Negro had available many more clinic hours per week than white persons. In 1930, this was 15.2 per 100,000 for the Negro and 7.3 per 100,000 for white persons, or a ratio of two to one. By 1939, these services had increased almost fourfold for both groups, so that Negroes had available 63.9 clinic hours per week per 100,000, as compared to 26.0 for white persons. It must be kept in mind that the gains during this 10 year period may not be quite this much, since the same population totals were used for 1930 and 1939; even so, there appears to have been marked progress in this field during this 10 year period. This same advance is of course to be noted when all of the counties which reported data for 1939 are considered. Here, again, the Negroes have twice as many clinic services as white persons. This forward march is also noted from another angle. In 1930, of the 32 counties, 17 did not have any venereal disease clinics for either racial group. In 1939, of the same 32 counties, only 4 reported in the negative. This is even better when all of the 63 counties reporting in 1939 are considered, for in this group only 4 had no clinic facilities for Negroes, but 8 had none for white persons.

This remarkable achievement during this decade must be attributed to the tremendous emphasis which has been placed on venereal disease control since 1935. One must not lose sight of the fact, however, that the proportion of facilities is not yet equivalent to the ratio of the venereal disease rate of Negroes to that of white persons. It has often been repeated for instance that six to ten times as many Negroes

TABLE 4

Venereal Disease Clinic Facilities in 1930 and 1939

Year	Counties Reporting	Population		Clinic Hours per Week		Clinic Hours per Week per 100,000	
		N	W	N	W	N	W
1930	32	421,025	826,533	64	60	15.2	7.3
1939	32	421,025	826,533	269	215	63.9	26.0
1939	63	951,855	1,674,222	519	413	54.5	24.7

TABLE 5

Prenatal Clinic Service Available in 1930 and 1939

Year	Counties Reporting	No. of Live Births		No. of Clinic Hours per Week		No. of Clinic Hours per Week per 1,000 Live Births	
		N	W	N	W	N	W
1930	21	7,046	9,855	13.2	9.8	1.9	0.9
1939	21	7,663	10,739	70.5	60.5	9.2	5.6
1939	50	14,863	21,039	148.5	131.0	9.9	6.2

have syphilis; therefore, a ratio of clinic services of two to one is still far short of the mark if need is the criterion of choice for the development of facilities. Also, it is to be emphasized that, even in 1939, almost 15 per cent of the counties had no clinical facilities for the control of venereal diseases.

3. Maternal and Infant Care — The problem of maternal and infant welfare is also of particular importance to Negroes, since their mortalities are generally twice as high as that of white individuals. According to Table 5, wherein 21 counties are compared for 1930 and 1939, it is found that, although Negroes had twice as many prenatal clinic hours per week for 1,000 live births as did white persons, yet the amount was far below the minimum of from 6 to 12 clinic hours per week per 1,000 live births suggested by Hiscock.[2] This was also true for the white population. By 1939, however, there was a sizable increase for both groups in the same 21 counties, so that Negroes received 9.2 clinic hours per week per 1,000 live births, while white persons obtained 5.6. Thus a five- and sixfold increase respectively was achieved for these two races in the decade 1930–1939, and the 21 counties in 1939 had apparently reached the suggested minimum level. This favorable position is also in evidence when all of the 50 counties which reported such services are analyzed. This advance certainly must in part be attributed to the recent stimulation given to maternal and child health programs through federal contributions under the Social Security Act promulgated in 1935. Without such financial stimulation it is to be doubted whether this marked progress would have taken place. Again, a word of caution must be interjected here. In 1939, 16, or about one-third of the 50 counties, reported no prenatal clinic facilities either for white or Negro pregnant women. If this is the situation in full-time county health units, what then must be the outlook in counties with no such organizations?

The proportion of babies delivered in hospitals and by midwives and the number of midwives in the community are also measures of evaluation of maternal and infant hygiene programs. In these spheres the Negro suffers by comparison. In Table 6, the percentages of babies delivered in hospitals and by midwives is considered. Fifty-four, or 86 per cent of the 63 counties, reported that in 1939 less than 10 per cent of the Negro babies were born in hospitals. If this group is further analyzed it is found that 22 of the 54 counties, or one-third of the 63 units, had no Negro hospital deliveries in 1939. For the white population, on the other hand, only 21, or one-third of the counties, had less than 10 per cent of their white babies delivered in hospitals. Of these 21, only 6 counties reported no white hospital deliveries.

It has often been said that the majority of Negro babies in the South are delivered by midwives. This table supports this contention. In 1939, 13, or one-fifth of the counties, reported that

TABLE 6

Per cent of Babies Delivered in Hospitals and by Midwives in 1939

	Race	Counties Reporting	Per cent of Babies Delivered in Hospitals					Counties Reporting	Per cent of Babies Delivered by Midwives				
			0-9	10-19	20-29	30-39	40 and Over		0-19	20-39	40-59	60-79	80-100
Number of Counties	N	63	54	3	2	1	3	68	13	3	5	21	26
	W	63	21	15	9	14	14	68	54	9	2	2	1

less than 20 per cent of their Negro babies were delivered by midwives; on the other hand, 80 per cent of the counties stated that this was true for white mothers. Furthermore, 26, or more than one-third of the counties, reported that 80 per cent of the Negro deliveries were attended by midwives, while only 1 county reported such a high percentage for white mothers. This condition is typical of practically the whole South, as shown by the report of the Bureau of the Census.[3]

The number of midwives in these counties is part of the whole picture and may be briefly described. In 1930, 57 counties reported a total of 2,938 midwives; these same counties in 1939 stated that they had only 1,943 of these individuals, or a decrease of more than 35 per cent. Using a population estimate of 943,274, we find that in 1930 there was 1 midwife for every 321 Negroes, while in 1939 this ratio had decreased to 1 per 485. This latter ratio holds true when all of the counties, 89 in number, reporting for 1939 are considered. With a total population in that year of 1,275,830 Negroes, they had 2,772 midwives, or 1 for every 460 persons. During the period 1930–1939, 8 of the 54 counties showed an increase in the number of midwives; 3 remained the same; 43 showed a definite decrease.

Registration and supervision are essential aspects in the program for continuous improvement of the midwife and therefore should be in force in every community. Of 87 counties, 80 have undertaken such a program, but 7 still neither register nor supervise their midwives. Of 71 which have this program of supervision, one-half instituted it during the decade 1930–1939; 3 previous to 1920, and the rest in the decade of 1920–1929.

It appears to us that for some time to come midwives, like poor relations, will always be with us; and certainly in many areas they fill a much needed gap in the number of professional personnel and the availability of services. This being the case, every attempt should be made by all health units confronted with this problem to develop plans for their improvement. This should be done by supervision, classes, and inspections. In addition, the utilization of trained nurse-midwives will help in supplementing and aiding this service.

4. School Hygiene—It was very difficult to analyze the data in this sphere of activity because of the meagerness of the information received. This incompleteness may signify that such programs have not been fully developed and are in the rudimentary stages; or that data separated on the basis of race are not available. The former statement is no doubt the truer explanation, since Negro children, with the exception of mass immunization procedures, are as a general rule ignored in the formulation of school health programs.

The analysis of the data available shows that the health programs for Negro children consist in the main of visits by nurses. In 1930, of 37 counties, 21 reported that 100 per cent of the Negro schools were visited. However, in that year, 8 of the counties reported that Negro schools had not been visited, whereas the number for the white schools was 5. In 1939 conditions were somewhat better, since in 53 of 72 counties all of the Negro schools were visited and, for the white schools, the same held true in 61 counties. The number of counties reporting this deficiency in Negro schools was 5, while only 3 admitted such a lack in white schools.

The examination of school children is an important aspect of this whole program. Within itself it is an important educational procedure. In 1930, 12, or 40 per cent, of 30 counties stated that Negro children were not examined, while only half this number reported the same for white children. The rest of

the counties reported various figures ranging from 8 to 100 per cent. In 1939 some progress is noticed. Eleven of 58 counties reported that no Negro children had been examined, but for the white children only 1 county admitted this deficiency. Thirty-eight of the 58 counties examined 50 per cent or more of their white children, but only 23 reached this level for Negro children.

Dental services which may be considered part of this program show an even greater lag for both white and Negro children. In 1930 all of the 27 counties which reported on this phase admitted no dental services for Negro children. Of these same 27, 3 admitted having services available to white children; 1 had given services totalling 748 items; another relied on the State Health Department trailer, and the third had its own clinics. By 1939 this picture had changed a little for the better. Of 44 counties reporting, 12, or about 30 per cent, provided dental services for Negro school children. These 12 counties which are listed below reported an approximate total number of 5,500 items of service.

COUNTIES REPORTING DENTAL SERVICES FOR NEGROES

1. Jefferson, Ala.
2. Orange, Fla.
3. Worth, Ga.
4. Caldwell, Ky.
5. LaSalle, La.
6. St. Martin, La.
7. Anne Arundel, Md.
8. Pitt, N. C.
9. Columbus, N. C.
10. Berkeley, S. C.
11. Hardeman, Tenn.
12. Albemarle, Va.

More services were, of course, available to white children in 1939. Of the 44 counties, 24, or more than 50 per cent, reported dental services for this group to the extent of 30,000 items.

Although progress is shown in the availability of dental services for Negro and white children, yet the amount of services rendered is still very meager when compared with the total school population of these counties. This is particularly true in the case of Negro children. This problem, like others, needs to be attacked by health departments. The employment of more dental hygienists might partly solve this problem. This professional group could be used for screening children with defects while state or county trailers could engage in the follow-up work. These dental hygienists could also be used effectively for health education. Even though this approach appears quite feasible, nevertheless, there will always be two obstacles to the development of dental programs in schools: (1) the economic position of Negro rural families; and (2) the wide scattering of Negro schools in many rural communities.

Postgraduate Courses and Fellowships—An attempt was made to discover the availability of courses and fellowships for Negro personnel in these health departments. As a whole they are not plentiful. In the decade of 1930–1939, of 83 counties only 1 had offered postgraduate courses for Negro physicians; only 1 had done so for nurses, and 6 had offered courses for others; mostly midwives. These counties were more generous in awarding fellowships. Of 84 counties, 5 had granted 8 fellowships to physicians and 6 had granted 7 to Negro nurses.

SUMMARY

Ninety-six southern counties with full-time health units were investigated by the questionnaire method in reference to the progress which had been achieved during the period 1930–1939 in certain public health services available to Negroes and white persons.

The analysis reveals that, during the decade in question, progress has taken place along several avenues, but this has been slow in pace and meager in quantity when compared to the number

and magnitude of the health problems facing Negroes in the rural South. Some advance has been made in the provision of clinic services for Negroes and white persons in these areas, but still too many communities are without adequate clinic facilities. This appears to be true particularly of truly rural counties with small populations. This fact has already been emphasized in a recent study which concluded: "Lack of clinic service to support the educational work of public health agencies is an outstanding deficiency of health organization especially for counties in the lower population group." [4]

Although tuberculosis is the foremost plague of the Negro, yet in this group of counties, he has available less clinic service and fewer beds per death. In the venereal disease field the Negro fares better—most likely as the result of the recent crusade—since he has twice as many clinic hours allocated to him per week as do his white brethren; but even this is not in proportion to the disparity existing between the incidence in the two races. The same outlook is to be found in the maternal and child health sphere. This study showed alarming neglect in the health supervision of Negro school children. In 1939, 11 of 58 counties reported no examination of Negro school children, while only 1 reported this deficiency for white school children.

On the basis of the analysis and opinions expressed by county health officers one may state that, in addition to the needs of clinic services for venereal diseases, tuberculosis, and the prenatal and postnatal stages, there is also a dire urgency for the development of a comprehensive approach to the manifold health problems of the Negro. What has been gained, may we ask, in a public health way when it is recorded in the files that a man has received 20 injections of bismuth and 20 of neoarsphenamine, and therefore has been discharged as adequately treated for syphilis, if his nutrition is poor, his teeth are decayed, his health habits are atrocious, he is diabetic, and his house is not properly screened?

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