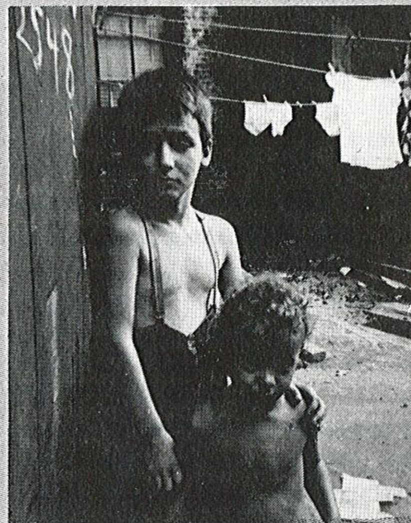
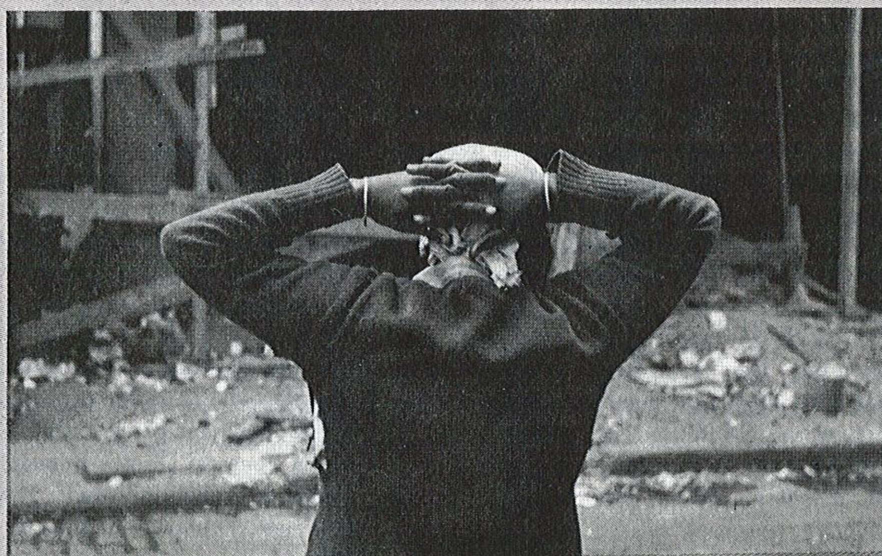
The Syndrome of Poverty





Resource ID 7960
The Syndrome of Poverty

We are all infected by the virus of poverty whose ills are social and physiologic and psychic, as complicated as fear, as commonplace as a bellyache, as contagious as measles. Eighty percent of us may run a subclinical course, showing no signs of the syndrome of poverty, but we cannot be well, even though affluent, if 20 percent of our fellows suffer acutely from the disease that is Too Little—too little money, food, housing, education, opportunity, respect, love, understanding.

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Between Those Who Have and Those Who Have Not

It is almost too late for those of us who are middle-class Americans to comprehend what poverty really means. When we conceived this month's feature on poverty we knew that there was still some bridge missing between those who really live deep poverty, and those who know it only vicariously. We believe we can come closer to providing that bridge by relinquishing our editorial page to one who, as a child, was a victim of the syndrome of poverty, and who today is witness to its ravages on others in her work as a public health nurse and as a volunteer worker in many community projects. Gloria Bigham had the strength to rise above poverty. But she knows that some of that strength came from others—many of them just middle-class Americans who knew how to use both their hearts and their knowledge.

BARBARA G. SCHUTT, R.N., EDITOR

Being poor, living in poverty, is indescribable. It's a vague mixture of poverty of emotional and physical health, poverty of social and spiritual well-being, poverty of economic security. Its effects are an inability to practice charity or to love, a kind of loss of faith, a kind of loss of hope, a kind of hurt for which there are no words, but which are devastating to those who are a part of this other America.

It is imperative that those of us who work with the poor—whether nurse, teacher, or health educator—have some understanding of this phenomenon. It is imperative if we are to accomplish the goal of health education: "To liberate man's potential strength, energies, and creative powers so that his actions become deeply satisfying and humanly constructive."(1) Each of us must have more than professional and technical competencies. My twelve years in public health nursing have convinced me that the first and most important qualification of those who would work with the poor is "heart": emotional concern, commitment, a belief in the inherent dignity of the individual, a kind of caring that is visible, that radiates from his or her very presence. I now know that the poor can sense the presence or absence of this quality, and will accept or reject us to the extent that we radiate this "heart." They want us to understand and help remove barriers—not to speak to them as if there were no barriers. They want us to treat them as individuals—not as a class. They want mutual acceptance.

There are implications in this belief for those who prepare professionals to work with the poor. It will mean a retooling of the mind on the part of some educators who insist that the poor are of a different breed with different needs, hopes, desires, and drives. There *are* differences, but those differences are man-made.

One professor recently expounded his theory of why there was more illicit sex among the subcultural group than among the dominant cultural group; yet he failed to mention that those in the dominant cultural group are more capable of hiding their sexual promiscuity; that the statistics on venereal disease are provided by agencies who serve the poor and thus are not indicative of the dominant group. William J. Brown, M.D., chief of the Venereal Disease Branch, Communicable Disease Center in Atlanta has said, "Private physicians treat an estimated 80 percent of all cases of venereal disease, yet only 11 percent of reported cases come from private medical sources. . . . The physician assumes that syphilis is a disease of the lower socioeconomic groups and fails to look for it in the affluent, educated, well-dressed patient."(2)

Yet we continue to send public health workers from graduate school believing that the poor are different in their sexual behavior. The poor think we are either ignorant or are ignoring the facts—the Profumo-Ward case in England, the Bobby Baker and Walter Jenkins cases in Washington, the many incidents involving college students. The poor know the frequency with which the dominant-group male uses the subculture prostitute because the poor see it daily. They laugh at us. The poor do have problems but they are general problems, and those who work with the poor should understand

this lest they tend to consider the poor as different, as lower beings whom they must reform and save.

It will mean a retooling of the minds of those educators who still teach that puritan ethic: if one works hard, one gets ahead. They must accept the fact that in reality all citizens have not had the same opportunity to become educated, or to obtain employment; that there have been barriers, but that we are working toward removing them. One of these barriers is the feeling that those who are poor are there because they want to be and thus are not deserving of our concern or empathy.

I resented my family and the school when, after graduation from high school, I answered many newspaper ads, seeking work which would enable me to pay my tuition at the university. I was told, ever so kindly, "We do not hire or place Negro girls." I slowly began to lose my hope and faith. One day I arrived home in tears and said to my mother, "Why didn't you tell me?" "If I had," she answered, "you would not have tried. You must not give up. Get more education."

I had worked hard in school, doubly so since I could not get help at home because my parents had limited educations—my father three years of school, my mother nine. There was no one person at school for me to reproach. Later I watched my husband die a little bit each day when he was told, again so kindly, upon graduation with a university degree in business administration, "We are not ready for Negro white collar workers." The hurt is indescribable.

It will mean also a retooling of the minds of those of us who believe we have made available adequate medical and social services for the poor, but that the poor simply have refused to accept them. The quality and quantity of these services have left much to be desired, according to reports such as the *Study of Services to Deal With Poverty in Detroit, Michigan* (conducted by Greenleigh Associates Inc. in 1964). Personally, I believe that in this city of Detroit, where I have been a supervisor of public health nurses for the past eight years, we have provided a shamefully inadequate amount and quality of care for the many who have been destitute and ill. I recall a little boy who was having epileptic seizures in school regularly because he did not have his medication. His mother had been told not to return to the hospital for it unless she had four dollars. She did not have it. The boy had the seizures, and the school called me. I called the hospital for the medication, and finally stated that I was prepared to beg for it, if necessary. The child received his medication .

It will mean a retooling of the minds of those in the medical sciences who consistently ignore the studies of the social and behavioral scientists. Two years ago I heard one new nurse graduate say very seriously: "Young Negro girls cannot help the fact that they are oversexed and this accounts for their high illegitimacy rate." Goode maintains that illegitimacy is not a norm, and that even in societies where a high rate exists, a legal union is still considered the more desirable(3). Yet we in the profession still say that illegitimacy is an accepted way of life among Negro and other poor. I have yet to meet parents, rich or poor, black or white, who were not disturbed by illegitimacy in the family. They are, however, discriminate in sharing their inner feelings. They do not share their hurt with seemingly disinterested visitors in their homes.

William Griffiths, in 1957, said that if we expect behavior to be changed we must utilize the motivational forces in health work: those biogenic and acquired basic human needs that serve as the motivational determinants of behavior(4). Biological needs of sex, thirst, and hunger take priority; acquired needs of love, security, recognition, and acceptance can motivate behavior as strongly as the former, but the former must come first. The poor's major concern today—now—is surviving. How often are these principles really taught? How many students are even aware of them?

To mention these concerns seems to imply a sensitiveness on my part. Indeed, it is more than sensitiveness; it is a feeling of burning urgency, a plea for change, a cry for all of those who would work with the poor—black or white—to try to identify with them, to see the world from their different point of view, to present *ourselves* as helping, understanding, real persons. Perhaps the real problem for us—the professionals—is knowing ourselves.

I am here and a nurse today, because a nurse cared and her very being radiated this caring. I wanted to be just like Amanda Claybon, who is living and nursing today in Tulsa, Oklahoma, where I was born. I am a public health nurse today because there were some teachers along the way who cared about me when I had begun not to care anymore, for there were just too many barriers. They provided the support, the caring, the concern, which encouraged me to rise above the poverty surrounding me.

We can help others become contributors to society by demonstrating that we really do care. But we must be able to look within ourselves and evaluate our own behavior. And we must reflect a readiness to change our ideas, attitudes, and helping practices if we find ourselves wanting. It is difficult, perhaps agonizing, but it is possible.

GLORIA BIGHAM

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the Negro in one city but accepted as white in another. While, therefore, a poor self-image and reactive aggressiveness *may* be part of his psyche, they are likely to be less deeply imbedded than in the Negro. The Latin minority citizen consequently is less apt to blame the white man for his social failures, and more prone to accept himself as not so accomplished as the "Americano" or "Anglo." But today, youthful Negroes, Mexican-Americans, and Puerto Ricans are struggling more actively against their older images, just as the more white Americans are wrestling with false stereotypes of minorities.

WORKING WITH THE MAN WITH THE PROBLEM

In the shadows of these complexities, how do the patient and the medical person feel in the treatment situation? The person who asks for help does so because he faces a health problem which he thinks is beyond his competence to solve and so he will entrust himself to the medical expert. The more serious his difficulty, the more anxious and helpless he feels. If he is a parent bringing a sick or retarded child, there are added emotions of which he may not be totally aware—a sense of failure, crippling feelings of narcissistic injury, frustration, anger, perhaps the stabbing pangs of guilt. Besides bewilderment and confusion, many parents are acutely sensitive to the rejecting attitudes of others (9).

With such a tangle of painful emotion intertwined with profound feelings of racial difference, the slum-dwelling Negro mother, for example, brings her sick child to the white nurse. Deep within her is a feeling of racial defectiveness, social inferiority, and economic failure on which she may, unconsciously, blame the physical or mental wrongness in her child. Suppose the child was born out of wedlock and the mother feels shame and guilt for that, too? How can she express her failure as a mother? How can she trust this nurse who represents white authority, a hostile society, and, as a maternal figure, her own parents who possibly failed her? The Negro's conflicts around dependency, anger, guilt, fear, frustration, and helplessness are all underscored by his racial infirmity.

With Mexicans and Puerto Ricans most of these considerations, but in less intense form, also must be taken into account. In addition, cultural and language barriers obstruct Latin minorities' efforts to obtain medical help. Furthermore, these citizens, particularly the older ones, may have fatalistic attitudes toward illness and death which are uncharacteristic of Americans. This resignation, makes it hard for them to plan and follow long-term treatment of any kind.

The medical person facing a patient from the minority group has, understandably, problems with his feelings that run as deep as his patient's. While there is satisfaction in giving to another what he lacks, there is also narcissism. Having someone depend on us can be fearsome, annoying, even repulsive. Seeing illness in another can arouse sympathy. It can also tap feelings that lie deep within us all about the worthlessness of persons who deviate markedly from "normal" standards and about the futility of offering help. We may feel guilty because misfortune has befallen them while we escaped (9).

The health professional's emotional response to the sick Negro, Mexican, or Puerto Rican takes upon itself the racial dimension. This patient "deviates" from "normal standards" not only because of illness but

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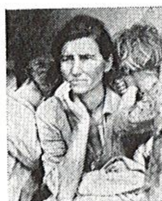

A Smoother

Years of studying the plight of our perhaps most-neglected minority group—migrant workers—are culminating at last in action to furnish medical and nursing care, and health education at migrant family service clinics dotted across the national map. Sponsored by community groups, these projects are supported jointly by the U.S. Public Health Service, under the Migrant Health Act, and by local permanent residents who are interested in the health of their temporary neighbors, the migratory farm employees.

Placing a man on the moon is a goal that we as a nation approach with confidence. But to provide continuous medical services for migrant people as they move from one work area to another is a task that still confounds us!

The accusation, "When you can't resolve a problem, you conduct a study!" has some validity in the migrant labor field as reports of national, state, and local commissions accumulate on dusty shelves.

From the report of the Country Life Commission in 1909 to the latest findings, the recommendations are monotonously alike: improve housing, license and supervise camps, guide workers, raise family income, provide adult and child educational opportunities, extend health and medical services, establish day care for children, and so on.

Yet the million U.S. migrants who move seasonally for agriculture work still exist under substandard conditions. They continue to have long idle periods when no work is available. And they continue to have difficulty in gaining access to community serv-

because of color, poverty, emotional scarring, hypersensitivity, and all the ugly concomitants of deprivation and segregation. The more "abnormal" the patient's social, cultural, economic, and moral condition appears, the more profound the medical person's response, even though his feelings are to some extent beyond his conscious awareness.

Typically, we either convince ourselves that race or color are of no significance to us and our patients or we strain to give exceptional service because of the racial difference. Either way, the patient may feel rejected. When we deny race, a vital part of his identity is ignored. Where we over-react to race, we betray not only our discomfort, but an overvaluation of the racial distinction.

Another reaction, particularly of the clinician who must break unhappy news about a child's health, is the too vigorous effort to make parents accept the diagnosis or recommendations(9). This pressure may be perceived by the family as a kind of rejection. They may see the clinician as more interested in performing his professional role than in the child himself. The parents then tend to become more defensive, particularly when racial difference exists and where it is seen, consciously or not, as contributing to the child's illness. Among other numerous reactions of the medical person to a minority patient, there is frequently a partial withdrawal both from his patient and from his own feelings. Since the emotions of both clinician and patient can so parallel each other, we might say that each is withdrawing from the frustration, fear, helplessness, and guilt which they share.

Nevertheless, the minority citizen continues to seek help and the professional attempts to give it. Most nurses and doctors are conscientious about their work. Government organizes and supports; civic groups band together for drives and meetings. Yet, the ills of these minorities which become the sickness of the nation increase in gravity. The pain experienced by a few becomes the nation's. The pain grows, we wince, and finally cry aloud for solutions.

No one, it seems, knows the cure, but we all—and this includes the minorities—know it lies in each of us individually and collectively. What we have done has helped, but it has not been enough. The condition of suffering people is not ordinary. It is extreme. Our saving efforts must also be extreme, more than most of us have dared imagine. In order not to succumb, we must give more understanding, imagination, invention, strain, and time. And, just as we are all the children of society's ills, we also must be the cure for those ills.

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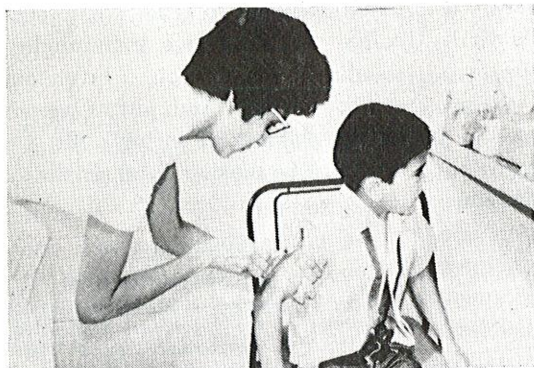
Road for Migrants

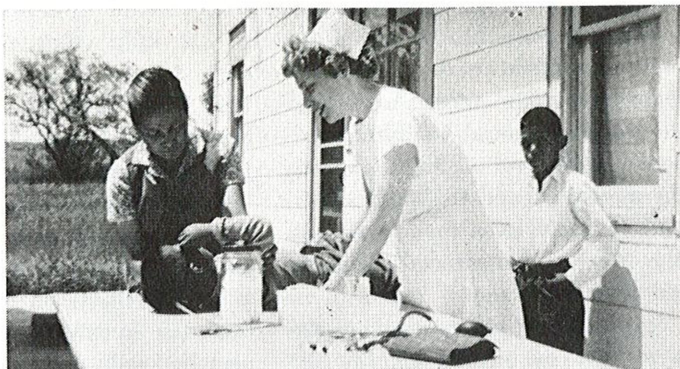
HELEN L. JOHNSTON

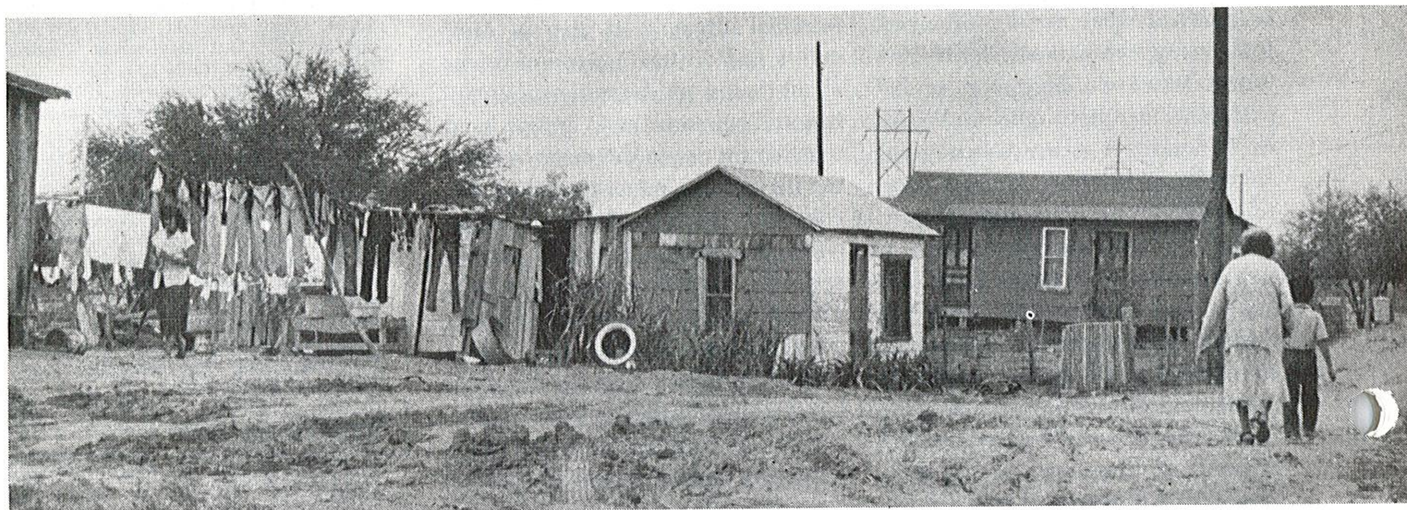
ices—meager in some work communities, or offered at points far from migrant locations, and often restricted to local residents. That so little has been done to implement sound recommendations may reflect the intrinsic difficulties involved.

The greatest obstacle is that solutions to problems cannot be achieved in any single place. The migratory farm laborers, some two to three million men, women, and children from various socioeconomic minorities, live during the winter in the southeast and southwest. The agricultural areas to which one third of this population travels during a given year are scattered widely over the whole United States. Altogether, nearly 1,000 counties in 48 states are encompassed by the three major streams of migration: one along the east coast, one along the west coast, and the third fanning out from Texas to all the central states. Therefore, plans developed in south Texas for Spanish-speaking migrants must be fitted in with solutions in such northern states as Michigan, Wisconsin, the Dakotas, Montana, Washington, and Oregon. Migrant programs in Florida for southern Negro workers must be coordinated with those in Virginia, Pennsylvania, New York, and other states.

For example, one 12-year-old boy who had poliomyelitis at eight months, was seen last summer in a Pacific Northwest county. During the previous five years, he had been examined and had his braces repaired in California, Texas, Louisiana, Idaho, and Oregon. His 1965 examination indicated the necessity for corrective surgery. An application







NURSES working in migrant health projects find themselves practicing in a variety of settings. Those shown above are in Wisconsin (top left) and Kansas (top right). Long-term reforms must be tied in with solutions to such problems as housing and sanitation.

was made to a private charitable institution. His family waited until late fall for his appointment—only to be told to come back in six months *if* they returned to the same work area!

Often more than one family member has a serious health problem. For instance, all but 1 person in a family of 13 had positive tuberculosis test reactions. Although the father had been ill most of the summer, he would accept neither testing nor an x-ray, but his nine children were x-rayed. For four of them, the physician recommended prophylactic Isoniazid for two years. However, because this family left the area within three days, local nurses only could send a detailed report to the state where the family reportedly spent the winter in the hope that they could be found and treated there.

Long-term, practical reforms in health care must be fitted into solutions of such problems as housing, sanitation, employment, low family income, community-migrant relationships, and education. Programs which aid one migrant group may not help others, at least not without modification to suit their inherent differences. Language variations among migrant groups are obvious, but health workers must recognize the more subtle distinctions among people and groups if they are to serve migrants effectively. For example, a high-school educated migrant who is potentially a helpful ally is quickly alienated if an approach to him is based on the false stereotype that all migrant workers must be illiterate.

Critical to gaining acceptance of medical services by migrants are the professional workers' understanding of migrants and the readiness of health personnel to shape their attitudes, their services, and the settings where these are offered to the people and their situations. Too often in the past, migrants have been called "uncooperative" because they failed to adopt local health patterns—patterns which might vary in each work community. Confused, migrants may justifiably have looked upon health workers as hard to understand or reach.

Not the least of the past difficulties has been lack of funds. Typically, those communities interested in assisting migratory families lacked the necessary nurses, sanitarians, and health educators, and had no money to employ more staff.

With the 1962 passage of the Migrant Health Act, things took a heart-

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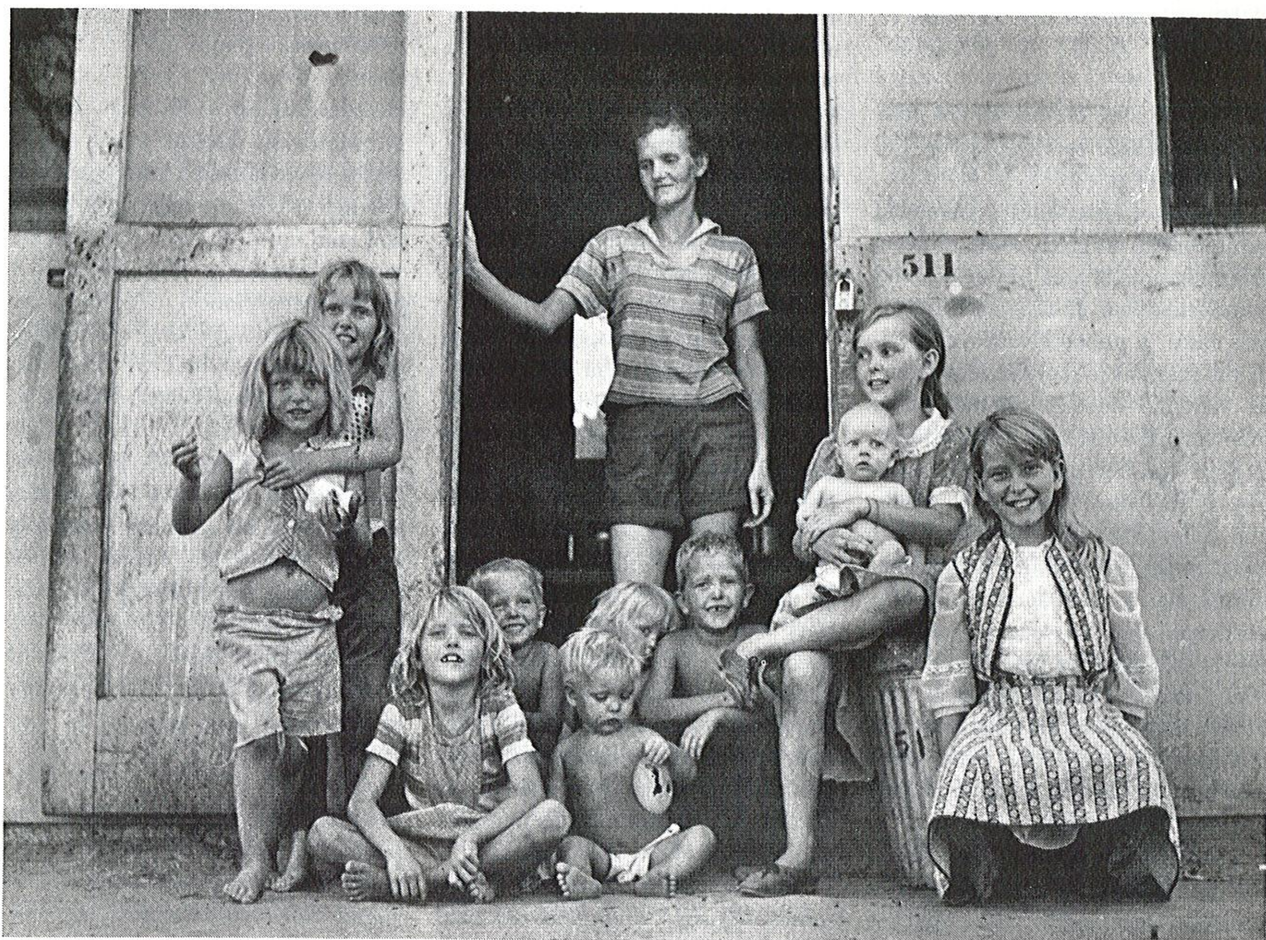


GENERAL MEDICAL CARE to families is provided by nearly two-thirds of the migrant health projects. Although statistics are difficult to collect, project workers report more mothers seeking care in early pregnancy and fewer children with acute diarrhea.

ening turn. The Act authorized grants by the U.S. Public Health Service to either public or private nonprofit groups for part of the cost of family service clinics or other activities to improve migrants' health services and conditions. The original, three-year authorization was an experimental measure to assist community-sponsored migrant projects, and in this process to delineate more precisely the extent of migrants' health needs. Once a realistic community service was established, migrants themselves could be encouraged to apply good health and safety practices.

Congressional reports at the time of the 1962 Act specifically enjoined against the payment of hospital bills on the premise that some hospitalization could be eliminated if migrants had early medical care, sanitation services to improve their living and working environment, and education to enable them to maintain good health. In 1962 Congress regarded an emphasis on prevention as more important than paying hospital bills.

By April 1966, 78 projects had obtained migrant health grants which paid about 60 percent of total project costs. The remainder is met by the applicant from other sources.

Some projects serve migrant farm workers and families in a single county or part of a county; others cover up to 15 or more counties. Most projects operate seasonally, with a dormant period in winter and renewed activity in the spring. Only projects in the so-called "home-base" areas, where migrants live during the off season and work if work is available, operate the year around. These homebase programs serve the reservoir population from which migrants are drawn, since no one knows who will move the following spring or which family member may join others in the north during the summer even though he had planned to stay in the south. Many projects began with limited services, or within a circumscribed geographic area but with plans to expand as they learned how to proceed successfully. Most have added more services, or modified their programs in other ways as they entered the second or third year of operation.

Sanitation, nursing, and health education—in that order of importance—are the services common to all migrant health projects. Otherwise the projects vary from area to area. Nearly two thirds provide general medical care to families, usually at night two or three times a week, at or near points of large migrant population. Ordinarily clinics are held in abandoned schoolhouses, church basements, or housing units in labor camps. A few projects transport mobile equipment from place to place during each week. The clinics usually are staffed by community physicians who are paid an hourly or

session fee based on the rate for public health clinic services, or on the local welfare rate.

In lieu of extending generalized family health services, some projects refer migrants to area physicians and reimburse them at the fee for welfare cases. A public health nurse visits the migrant to determine whether he saw the doctor; whether he is following the doctor's instructions, and, if the referral was not completed, the nurse tries to learn why and eliminate any obstacles that stand in the way. Where physicians, nurses, clerks, receptionists, and others donate their services to a project, this is calculated as part of the local contribution. Dental needs of migrants have come very early to the attention of project staff. Other services include medical social work and nutrition.

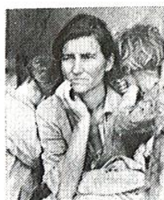
Public health agencies have led in the development of most community projects. Occasionally, the applicant is a local migrant committee, a board of supervisors, or some other interested group qualified to operate a health program. Project directors include physicians, ministers, a scientist, a hardware dealer, a school principal—many different community leaders who have won the support of local professional health workers essential in project operation.

Allies to project operation have sprung up regardless of the projects' auspices: local agricultural extension agents help to find migrant camps and participate in adult education programs; church groups transport patients to clinics or other agencies; day care centers and summer schools for migrant children refer sick youngsters and teach good health practices; the Lions Club often buys glasses for migrants; and the public employment service not only determines where migrants are, their numbers, and how long they will stay in an area, but it also informs migrants and growers about the project.

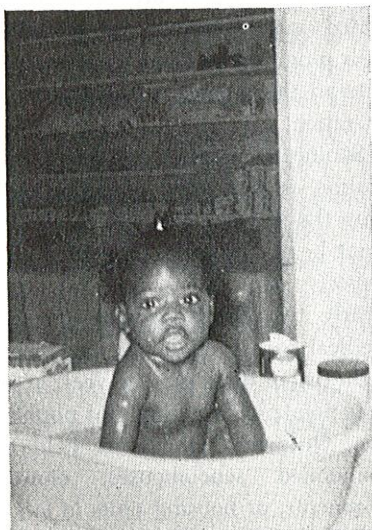
With the annual turnover in migrant "census," and the seasonal turnover in every project area, the usual measurements of health and services—morbidity and mortality statistics—are extremely hard to come by. However, project staffs report seeing fewer children with the acute diarrhea that requires hospitalization, and more mothers seeking care early in pregnancy. They also note a growing acceptance of services by migrants and increasing community participation as cited in these excerpts from annual project reports:

Among crewleaders [the persons responsible for recruiting and finding jobs for migrant workers, especially on the East Coast], some showed "a surprising responsibility and concern for members of their crews." We got good cooperation . . . in regard to transporting patients to clinics and in referring sick persons to our staff. . . .

Although one grower objected to having his workers approached . . . , most were very cooperative and stated that they were glad more ef-



Migrant Day



MORNING BATH and breakfast start the day at this center for migrant youngsters.

This nurse's story of her two weeks with migrant youngsters, whose parents had no choice but to leave them in each other's care until local residents developed a children's day center, changes "minority members" into living humans—hungry babies, eight-year-olds who cannot spell their names because following the crop circuit short-circuits their every term in school, or 11-year-olds who work as field hands. Perhaps this warm account of nursing migrant children will encourage the reader to be one of those for whom "a long drive, small pay, and hard work" may be a lure rather than an obstacle to doing something for migrants, our "most checked-on and least done-for" fellow workers.

Last summer I spent two of the most interesting weeks of my nursing career relieving the one registered nurse employed at a day center for the children of migrant workers in Au Clair, Michigan. At 6:30 A.M., using an old school bus owned by the Council of Churches which sponsors the Center, two volunteer church workers brought to the Center 50 or more youngsters, babies, and 1- to 10-year-olds who had been left at "home"—the migrant camps—by their parents.

Mothers, fathers, and children aged 12 or more left the camps around dawn to harvest cherries, raspberries, asparagus, and peaches —as many as possible since they are paid by the crate. Although the small babies and toddlers were left in the

forts were being made to provide facilities and services for migrant workers. One grower's wife paid for braces for a migrant child when the need was brought to her attention. . . . Another grower paid a hospital bill for a child with diarrhea. . . .

As physicians saw the needs of the migrants, they gave much more freely of their time, professional services, and even supplies. Nurses who had been unfamiliar with the migrant situation became champions for promoting better health measures and seeing that the migrant workers found medical care. (Some of these nurses had been inactive, had had no previous public health preparation or experience, and had been recruited for short-term project employment.)

There is a feeling in the community that such a program has many advantages, not only in the health area but social as well. All personnel . . . found the migrant families easy to work with and cooperative.

Some projects still report frustrations: the limited time in which care must be given; the nonattendance of migrants at family health clinics which are far from their camps; overcrowding of project clinics with consequent lack of privacy or time with patients; inability to find the extremely mobile migrant to determine the outcome of his referral, or to carry out a referral from another project area; the lack of receptivity of those migrants who need assistance most.

With regard to difficulties in obtaining hospitalization for patients, a national evaluation team working under the American Public Health Association commented that exclusion of the migrant and his family from hospital care was the most frequently and universally mentioned deficiency in the program and the principal deterrent to adequate care.

When the Migrant Health Act came before Congress for renewal early in 1965, it was extended for three years, the prohibition against use of grant funds for payment of hospital bills was removed, and the appropriation ceiling was raised. Hospitalization is limited to 30 days for any one admission and applies only to care in general short-term agencies. It permits such payment to hospitals only by approved projects which offer general medical care through family clinics or other arrangements geared to migrants' work and life situations.

Project applicants for hospital care monies must furnish evidence of migrants' need for hospitalization, and of hardship to hospitals if reimbursement is not made. Applicants also must establish agreements with hospitals to serve migrants at pre-established rates based on reasonable costs.

The migrant's road is still rough, but his chances of finding health services along the way are improving. And communication among health workers serving the migrant in his journey grows easier as the United States map becomes dotted with projects trying hard to serve him and his family. △

Care Center

MILDRED YANKEE

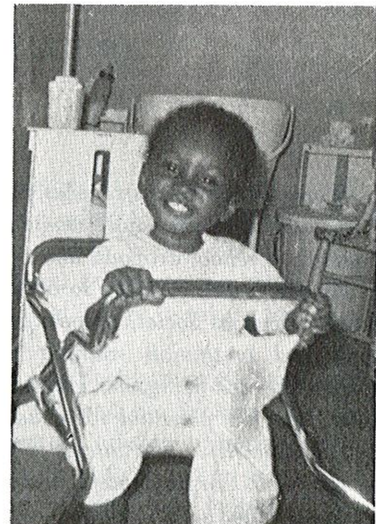
care of their 8- to 10-year-old brothers and sisters, they got a large measure of love and attention from everyone, blood relative or not.

Occasionally, the 11- and 12-year-olds visited the Center when they were not at work in the fields.

The Au Clair Center was established three years ago by the Council of Churches; it was equipped through donations of used cribs, toys, and baby clothing; and is operated by local people able to give their time and do the hard work of the Center. Area farmers contribute fruits and vegetables, but most of the food consists of government-surplus commodities. The Berrien County Welfare Department pays $4.00 per day for each child, very few of whose parents can afford to pay for their care.

When I reached the Center a little before seven o'clock each morning, the director, the cook, and laundress already were plunging into their respective jobs. As the children arrived, each baby in his own plastic tub labeled with his name was brought to the nursery, our only screened area; the toddlers went to another room where volunteers fed and played with them and later put them on cots in the playroom for naps.

Food was the first order of the day —formula, baby food, or regular food depending on the child's age and health needs. Whether the meal was breakfast, dinner, or the morning and afternoon cookie break, the youngsters always ate every bite. Some had



SHINING health had replaced dull, malnourished looks by the end of the summer.

three servings. For breakfast they tucked away quarts of oatmeal or cream of wheat, milk, eggs, and fruit. At noon, the cook devised a dozen ways to serve macaroni, hamburger, and hot dogs. The Center supplied formulas, even Similac, for infants who needed them.

In the nursery, which accommodated 12 babies, my volunteer helpers and I undressed the 3- to about 16-month-old babies, bathed them, clothed them in diapers and gowns, and placed their clothing in individual containers, pinned together, for the laundress to wash and dry before 2:00 P.M. We weighed the children and shampooed their hair weekly, but since most infants as well as older boys and girls had head colds, and because so many babies ran fevers, I made it a practice to take their temperatures every day.

MRS. YANKEE (Macon Hospital School of Nursing, Macon, Ga.), a busy farmer's wife, does part-time nursing at the Cass County Hospital, is adviser to the Southwestern Michigan Girl Scouts, and has become a champion for promoting better care for migrant workers through her volunteer work at campfire services in migrant camps and her two weeks' full-time nursing in the Au Clair, Michigan Migrant Center.

Our Center physician, Dr. David Hills, a former medical missionary who now practices in Benton Harbor and works through the Council of Churches, left directions—Quintess for diarrhea, Triaminic for runny noses, baby Aspirin for fevers. I had a few rough moments until I learned the difference between infectious diarrhea and the type caused by the home diet of whole peas, unmashed corn, and beans fed to babies who do not have all their teeth. For those with early morning temperature elevations, I would start Aspirin and liquid feedings. But by noon, or whenever they passed the whole boiled beans and corn, the babies' fevers subsided. Nearly all breast-fed infants had diarrhea because their mothers naturally had eaten too much fruit while they were picking. These babies we placed on formula. Along with infant, extra clothes, and a note to his mother, we sent home evening baby food in the plastic tub to discourage the meals of whole vegetables which were all that some migrant parents could afford.

Older children watched us by the hour through the nursery windows, and often asked to hold "their babies." Each time the door opened, battle was joined with the flies. All six, large, unscreened outside doors to the Center were flung wide as the children raced in and out.

After the babies were full and clean and comfortable, I looked after those outside the nursery. Some were so shy that they could only cry when they needed to go to the toilet. Very few children of any age could write their names since they hardly ever finish a term at school as they follow the crop circuit in the big open trucks with their parents. Many of my treatments were makeshift. After I'd dressed one barefoot six-year-old's stubbed toe four times and it had been stepped on four times, I hung a sign around his neck saying, "KEEP OFF!" This worked until someone tore it up, but everyone became conscious of Theodore's toe.

Besides colds from Michigan's cool nights and hot days, the children had cramps, draining ears, and worms—hookworms from southern states like Louisiana, Georgia, Tennessee, and Alabama, and pinworms from everywhere. A trip to the bathroom usually cured the fellow who said, "My stomick hurts, Nurse." Run-of-the-mill cuts and bruises I could attend. For Dr. Hills' clinic held regularly on

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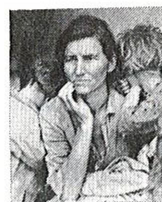

A Better

The Women's Job Corps reaches out for the hard-to-reach young woman, frequently a school dropout, and offers her the health care she so badly needs, as well as social, preoccupational, and on-the-job training to improve her well-being, her employability, and her potential for a useful, enjoyable life. The nurses who staff the Job Corps Centers, along with many other health workers, contribute broadly and specifically to this brave social experiment to reach girls who are not delinquent but whose homes are inadequate.

She was only 17 when she came to the first Women's Job Corps Center in St. Petersburg, Florida. A bit frightened, she held her suitcase in one hand and a well-worn stuffed dog in the other. "I call him *Tomorrow,*" she shyly told the interviewer, "because that's all I've got."

The door to tomorrow was opened for this girl and 1,200 others like her in Florida, West Virginia, Ohio, Nebraska, California—girls who have one thing in common, poverty. Not just economic poverty, but the whole spectrum of "not enough"—not enough education, food, money, or clothing; not enough medical care; not enough love and supervision at home.

The Economic Opportunity Act, passed by Congress in August 1964, created the Women's Job Corps primarily to establish residential training centers for disadvantaged young women from 16 to 21 years of age, to help prepare them for their triple role as homemaker, worker, and citizen.

The job corps program offers a totally new, multidisciplinary, inte-

Thursday evenings, I left a list of children with infected ears, respiratory symptoms, and worms. Dr. Hills tried to see all members of each family who brought in their youngsters. Most parents attended clinic and followed his recommendations. A few did not, and occasionally medicine sent home was returned the next day, especially medicine for baby rashes of various kinds. But the children were cared for if parents allowed them to be brought to the Center.

If the family did not come in, the doctor, the director, or the social worker from the Berrien County Welfare Department—usually the director—tried to reach them. Investigating the camp where one baby apparently was poisoned with an insecticide, the director found that the owner had given this baby's mother a bedbug spray. After spraying liberally with the insecticide and kerosene, the family had slept on a pile of ragged quilts. The baby's wet diaper speeded absorption of the spray with the result that her skin had peeled off from her hips almost to her knees. The previous summer one migrant woman's exposure to the same insecticide had caused scarring and a partial paralysis of her neck, shoulder, and left arm. We bathed the baby immediately with Dial soap, applied Vaseline, and called the Poison Spray Control Unit for the tricounty area of the Cass, Berrien, and Van Buren Counties to which we reported all incidents of spray-caused conditions. The Unit referred us to a dermatologist, who ordered an ointment that worked amazingly well—when she was seen the next evening at clinic, the baby's skin was almost completely healed.

BEFORE AND AFTER

When the 1965 harvesting season began, many youngsters had the protuberant abdomens and signs of severe dehydration one sees in pictures of Indian or African children, but by the end of summer, they had lost their dull, malnourished look, and were little bouncing balls of health.

The better toys and clothing were given to the migrant children on their last day with us. The children were overjoyed. Many of them will never come to this Center again, but they will remember its friendliness and kindness.

As each day ended and the youngsters, no matter how dusty from playing, hugged us goodbye—we couldn't take them to the lake *every* day to bathe—we could leave for our homes feeling satisfied. Weary, dirty, and with our hair a mess, we too had had a wonderful time. I did feel a bit peeved at the welfare worker who appeared one day, immaculate and cool, as we were ready to leave about 3:30 P.M. Closing the office door to eliminate flies and the bother of departing children, she quizzed us at length about the social worker and about the improvements she desired, but did nothing to obtain, in our housekeeping unit crowded into the back of the building and alive with flies and kids. When an urgent call interrupted her recommendations—a call about a grass fire started when our trash barrel incinerator tipped over—I was tempted to invite her to help us put out the fire, to get us a wire container for burning rubbish, more screens, and someone to teach the children to spell their names. . . .

Although we left the Center that afternoon feeling more analyzed and trod upon than the good-natured migrant who is perhaps the most checked-on and least done-for person in the U.S., the next day we could all laugh. We were all too busy to harbor resentment. △

Start for Girls

MARILYN SCHIMA

grated education to girls whom conventional schooling has failed to benefit, who need a complete change in environment, and for whom no other community program exists.

Mostly school dropouts, job corps applicants are some of the 350,000 girls who leave school every year. They constitute one-one hundredth of the 35 million too long-forgotten Americans who live below the poverty line: the uneducated, unskilled, and unemployable.

Without preparation for today's world, these girls look forward to the bleak prospect of joining the 14 million impoverished women who represent *25 percent* of the nation's poor. Many will assume responsibility as heads of families. At present, half of all poor families are headed by widowed, deserted, or divorced women and two of every five poor families headed by women have no wage earner (1,2,3).

Whether these girls contribute some income to their future families or wholly support them, each will help decide how the family's money is spent—what foods to purchase, whether her children drink milk or coke, when to see a doctor, whether or not to seek prenatal care, the dozens of day-to-day decisions that strengthen or weaken her family's well-being.

A critical part of the nation's War on Poverty, the Women's Job Corps Centers offer a voluntary training program of one to two years depending on the girl's individual needs. This entirely student-focused program provides basic education, home and family life education, counseling and guidance, remedial health care,

health education, occupational and preoccupational training. Occupational training is given in those areas where a demand exists in the labor market such as business operations, retailing, food preparation and services, and health occupations. It is the first national program constructed for the disadvantaged girl at a time in her life when, all too frequently, growing up means marriage and going on relief, or having a child or two and going on relief.

The only countrywide attempt to reach the hard-to-reach, the job corps is the first program in which girls who are not delinquent, but whose homes are inadequate or intolerable, can find adults whose only job is to help them. Because the average job corps enrollee has not known appropriate home, school, or community role models for her future position as wife, mother, worker—decision-maker, if you will—the job corps aims to provide the experiences and skills which should equip her to be that key person who encourages her children to stay in school, her husband to stick to his job, and guides her whole family.

THE GIRLS

Job corps girls, whose average age is 18, come from all United States urban and rural areas, from all races and religions, and bring with them a vast range of human experience to share with others. They come from large families—the number of families intact equals the number broken by divorce, death or separation. Educational achievement levels range from fifth to twelfth grades; the average is ninth grade.

Aside from their home environment, these girls are typical teenagers—curious, eager to work, energetic but with short attention spans, shy but interested in people. They are rebelling on the one hand but looking for mature guidance on the other.

Coming from the downward movement of the poor into ever-deeper poverty, they see in the job corps a hope for upward mobility. One enrollee said, "I prayed for the chance not just to turn the corner but to put my foot on the stairs."

Job corps girls are selected by the WICS, or Women in Community Service, a group established for recruitment by Dr. Jeanne Noble, organizer of the Women's Job Corps Division for the President's Task Force. The WICS is composed of an interfaith, interracial group of volunteer women who are among the 27 million members of the National Councils of Catholic, Jewish, and Negro Women, and the United Church Women. Since local community women know which girls need job corps the most, the WICS have been very effective recruiters.

Applicants to the centers desperately need remedial health care. Many have never visited a doctor or dentist. Lack of medical supervision, impoverished homes, and inadequate community services leave these girls —in the supposedly healthiest phase of their lives—with marked health deficiencies.

Every girl has a thorough physical and dental examination. For many, this initial contact with medical people is the beginning of a broad health education program designed to reduce their physical and emotional problems.

JOB CORPS CENTERS

All women's centers are located in cities where students may participate in community activities as well as on-the-job training. Presently, 11 centers are operating, with more being readied, in 10 states—California, Florida, Iowa, Maine, Michigan, Missouri, Nebraska, New Mexico, Ohio, and West Virginia. Sponsored by such diverse groups as boards of public instruction, a Negro sorority, the YWCA, and industrial firms, these centers serve over 2,700 enrollees.

Any college, private corporation, public education agency, or national organization with a qualifying program may contract with the federal government to sponsor a center. Since previous approaches to educating disadvantaged persons have failed, job corps uses unprecedented organizational structures to discover an approach which may succeed. Inventiveness, experimentation, and diversity in methods are encouraged. Each contractor developes his program under broad guidelines drawn up by the Office of Economic Opportunity. He recruits, hires, and directs all center personnel.

NURSES' WORK VARIES

Nurses are vital members of the health team at all centers. The Cleveland center, for instance, has four full-time registered nurses who work from 8:00 A.M. to 12:00 midnight. With the medical director, they establish policies and procedures relating to health services and they operate the health service program. This center also has a nurse educator who works closely with the health educator to plan the training of girls preparing for various health occupations.

Minor medical care is given by the center nurses and doctors. Girls with major health problems are referred to specialists. The centers rely on community dentists to treat the approximately 87 percent of enrollees who arrive with gross tooth decay and needing extensive dental care, including prosthesis. Immediate basic education is a must. It begins with the simplist kind of help in areas most of us take for granted. Many must be shown how to make their beds. For some, sheets are a new luxury. So are toothbrushes, toothpaste, toilets, deodorants. Setting a table and sitting at one for a meal are often confusing tasks for these girls.

Many staff members contribute to the health education program: nurses, home and family life instructors, residential advisers, who live with the girls. An educator with a

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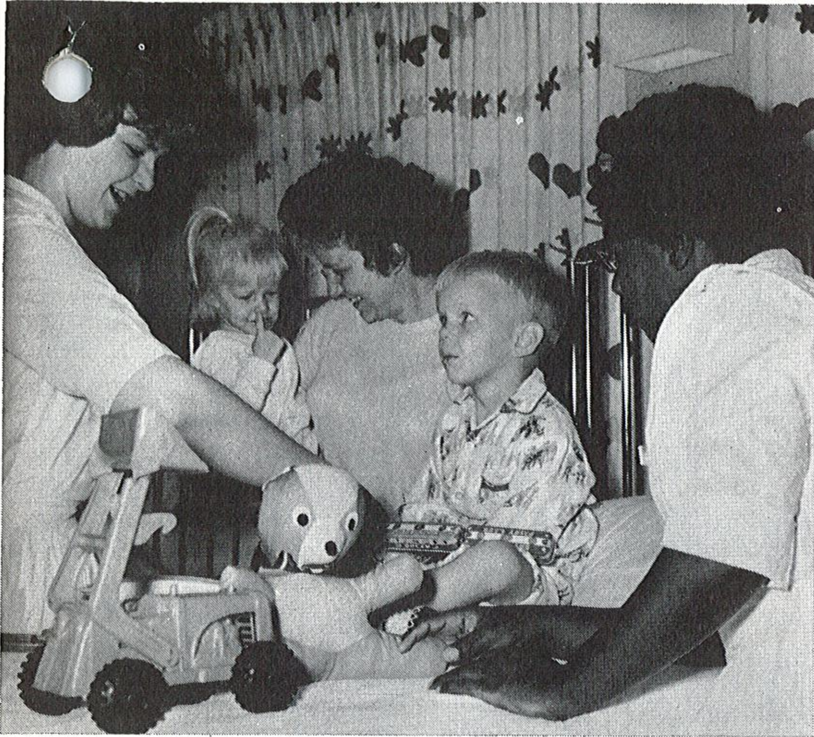

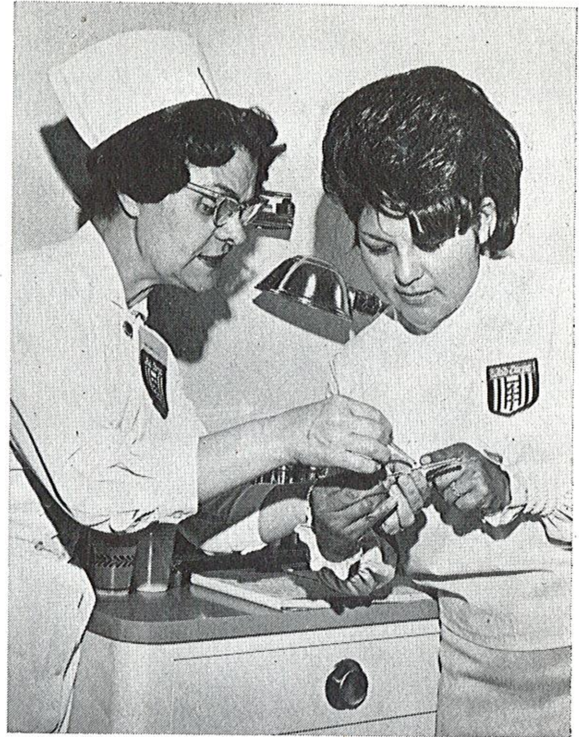

EAGER to enter health occupations, many girls at Women's Job Corps Centers train as nurses' aides as (left photo) Delores Clawson (left) and Shiela Morgan (right) did in Omaha. In right photo, Tess Kraft, a Cleveland center nurse, teaches Margaret Suazo.

degree in the human or natural sciences coordinates the program to educate enrollees in personal hygiene, nutrition, consumer information, safety, sex, stimulants and narcotics, first aid, and home nursing.

At St. Petersburg, a nurse with advanced preparation in public health nursing and health education is coordinator, responsible for planning a program which incorporates health services, health education, and preoccupational and occupational health training. All centers rely on local nursing associations for information about sources of additional personnel, the requirements of various health occupations, especially for nurse's aides and practical nurses, and to recommend nursing schools which can finance additional education for girls who want to move up the ladder.

Health occupations are the third highest career choices among enrolless. Often a girl is first interested in becoming a nurse's aide. As her skills improve and her self-image strengthens, she raises her sights to a more demanding career.

The nurses' division of the American Red Cross furnishes instructors, materials, and equipment to teach first aid and home nursing, and encourages girls to volunteer for the Red Cross Youth Program. After this apprenticeship, many girls should be able to volunteer assistance in a variety of health facilities. In a larger sense, the job corps will increase the pool of health personnel trained for disasters.

The centers attract members of many other disciplines—social workers, counselors, teachers, vocational educators, public and community relations specialists, administrators, business experts, and poor citizens who participate as members of each job corps' citizens' committee. The job corps approach and its success depend on this team to create programs emphasizing student self-help, involvement, and responsibility.

NURSES NEEDED

Generally speaking, each center needs the following nursing staff: four or more registered nurses; two nurse educators; two or three health educators who may be registered nurses with additional preparation in health education; and one health coordinator who may be a registered nurse with a degree in public health and health education. Applicants should direct inquiries to the personnel departments at the regional centers. Information about the job corps and other War on Poverty programs is available from state and local antipoverty committees, the Office of Economic Opportunity, Women's Job Corps Division, Washington 25, D.C., or local nurses' associations.

As the hopeful experiment in living and learning that is the job corps expands daily, nurses have a magnificent opportunity to contribute in the planning, guiding, and implementing of the preventive, service, and educational aspects of this social action program that should improve the health of their countrymen.

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