OLDER AMERICANS IN RURAL AREAS

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

PART 5—GREENWOOD, MISSISSIPPI

OCTOBER 9, 1969

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

48-387 WASHINGTON : 1970

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 30 cents

SPECIAL COMMITTEE ON AGING

HARRISON A. WILLIAMS, Jr., New Jersey, *Chairman*

ALAN BIBLE, Nevada
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
RALPH YARBOROUGH, Texas
STEPHEN M. YOUNG, Ohio
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana

WINSTON L. PROUTY, Vermont
HIRAM L. FONG, Hawaii
JACK MILLER, Iowa
CLIFFORD P. HANSEN, Wyoming
GEORGE MURPHY, California
PAUL J. FANNIN, Arizona
EDWARD J. GURNEY, Florida
WILLIAM B. SAXBE, Ohio
RALPH T. SMITH, Illinois

WILLIAM E. ORIOL, *Staff Director*
JOHN GUY MILLER, *Minority Staff Director*

Part 1. Des Moines, Iowa, September 8, 1969
Part 2. Majestic-Freeburn, Kentucky, September 12, 1969
Part 3. Fleming, Kentucky, September 12, 1969
Part 4. New Albany, Indiana, September 16, 1969
Part 5. Greenwood, Mississippi, October 9, 1969
Part 6. Little Rock, Arkansas, October 10, 1969
Part 7. Emmett, Idaho, February 24, 1970
Part 8. Boise, Idaho, February 24, 1970
Part 9. Washington, D.C., May 26, 1970
Part 10. Washington, D.C., June 2, 1970
Part 11. Dogbone-Charleston, W. Va., October 27, 1970
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970

CONTENTS

	Page
Opening statement by Senator Vance Hartke, presiding	323

CHRONOLOGICAL LIST OF WITNESSES

Henry, Hon. Thurman, mayor, Greenwood, Miss	324
Williams, Mrs. Leola, project director, food and nutrition program for aged, Star, Inc	325
Lucas, Earl S., center director, Star, Inc., Mound Bayou, Miss	328
Winel, Msgr. Roland T	329
Polk, Richard A., director, manpower and training, and deputy director Star, Inc., Jackson, Miss	332
Lott, Mrs. Annie, Greenwood, Miss	341
Henry, Mrs. Ophelia, Greenwood, Miss	341
Gosa, Mrs. Eliza, Greenwood, Miss	341
Brown, Mrs. Elder Leanna, Greenville, Miss	341
Hatch, John, director of community health action, Tufts-Delta Health Center, Mound Bayou, Miss	346
Weeks, David, M.D., medical director, Tufts-Delta Health Center, Mound Bayou, Miss	349
Feyen, Genevieve, R.N., Jackson, Miss	351
Moore, Connie R., center director, Star, Inc., Meridian, Miss	356
Sanders, Alix, representative, Mississippi Rural Legal Services	357
Dean, Kenneth, chairman, Mississippi Council of Human Relations	358
Williams, James E., director, project FIND, Winona, Miss	360
Fowler, Tal, regional representative, National Council on the Aging	363
Macheski, Rev. Nathaniel, St. Francis Roman Catholic Church	364

APPENDIXES

Appendix 1. Additional material from witnesses:	
Item 1. Submitted by Dr. David E. Weeks, M.D., deputy-clinical director of Tufts-Delta Health Center	367
Exhibit A. The Health Implications of Tufts-Delta Health Center	369
Exhibit B. Tufts-Delta Administers Environmental Treatment by Andrew James, R.S., M.S., director of environmental improvement Tufts-Delta Health Center, Mound Bayou, Miss	371
Exhibit C. A Stir of Hope in Mound Bayou by Richard Hall	377
Exhibit D. Health Center in Mississippi, by H. Jack Geiger, Tufts University	383
Exhibit E. Health Care in the Mississippi Delta by Cynthia Kelly	387
Item 2. A look at the elderly poor in the six-county target area in central Mississippi project FIND interim report June 1, 1968–September 30, 1969 (quarterly report submitted September 30, 1969) central Mississippi, Inc. Project FIND, Winona, Miss., James E. Williams, project director	
Appendix 2. Statements submitted by the hearing audience:	391
Easley, Will, Itta Bena, Miss	395
Ervin, Charlie E., Itta Bena, Miss	395
Gray, Mrs. Missouri, Greenwood, Miss	395
Humphrey, C. R., Jr., M.D., Fayelle, Miss	396
McCullough, Mrs. Hattie, Itta Bena, Miss	396
Pointer, Mrs. Louise, Greenwood, Miss	397
Pratt, Mrs. Pasty, Europa, Miss	397
Ramsey, Surloma, Greenwood, Miss	397
Thacker, Mrs. Cortia, Jackson, Miss	397
White, Mrs. M. J., Schlater, Miss	397

OLDER AMERICANS IN RURAL AREAS

(Greenwood, Mississippi)

THURSDAY, OCTOBER 9, 1969

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Greenwood, Miss.

The committee met at 1:35 p.m., pursuant to notice, in the St. Francis Center, Greenwood, Miss., Senator Vance Hartke presiding.

Present: Senator Hartke.

Staff members present: William E. Oriol, staff director; John Guy Miller, minority staff director; Thomas Brunner, special assistant; Peggy Fecik and Jean Znaniecki, clerks.

OPENING STATEMENT BY SENATOR VANCE HARTKE, PRESIDING

Senator HARTKE. Ladies and gentlemen, this committee meeting will come to order. This is the Special Committee on Aging of the U.S. Senate.

The hearings that we are having here today are called field hearings. They are very similar to the meetings that are conducted in Washington, D.C. We will follow the same general pattern that we follow in Washington, D.C., the only difference being that these are held outside the Capitol and are arranged for the very purpose of taking the Government to the people rather than requiring the people to come to Washington, D.C., to attend the hearings.

I want to express my appreciation to all of the people who have helped to make my visit here so warm and so gracious. I want to thank Mayor Henry for not only providing us with a warm welcome to this city, but also bringing us here in good order.

My statement today will be brief because we have many witnesses to hear from before we leave tonight for Little Rock, Ark.

I will, however, point out that this is the fifth field hearing to be conducted by the Senate Special Committee on Aging on the subject of "Older Americans in Rural Areas."

The first hearing was in Des Moines, Iowa, on September 8. The committee met again on September 12 for two hearings in eastern Kentucky; and then we heard from witnesses on September 16 in New Albany, Ind.

Each hearing has provided insights into unique local problems; and each hearing has also contributed to the overall objectives of the committee study.

Those objectives are:

To explore unique problems encountered by those elderly who live in rural areas, including economic or other pressures that may cause withdrawal from such areas.

To determine whether Federal programs and services intended to serve older Americans are as effective as they should be in rural areas.

To gather information that will supplement another committee study, "The Economics of Aging: Toward a Full Share in Abundance." Thus far, relatively little testimony in hearings on that subject has been taken on the rural elderly.

To seek recommendations for Federal action.

I know that you here in Mississippi have useful information about intense problems here, as well as significant attempts to deal with those problems. And so I will call the first witnesses, and I will offer special thanks to Mrs. Leola Williams for her help in making preparations for this hearing.

The first witness we will hear from will be your new mayor, the Honorable Thurman Henry, the mayor of the city of Greenwood.

STATEMENT OF HON. THURMAN HENRY, MAYOR, GREENWOOD, MISS.

Mr. Henry. Thank you. If you will indulge me a moment, I would like to tell this audience very briefly some of the many, many accomplishments of our distinguished visitor.

He was born in Stendal, Pike County, Ind., and educated in the Stendal public school system there. He is the son of the late Hugo Hartke and Ida Egbert Hartke.

Upon graduation from Stendal public schools, he attended Evansville College where he graduated with an AB degree. He attended the Indiana University Law School where he finished with a Doctor of Jurisprudence degree. He was a double scholarship winner; editor of the Indiana Law Journal; Phi Delta Phi and Tau Kappa Alpha (honorary fraternities); veteran of Navy and Coast Guard service in World War II, including supply and purchasing duties at Underwater Sound Laboratory at New London, Conn.

Upon finishing his military tour of duty, Senator Hartke returned to Evansville, Ind., where he became a practicing attorney from the year 1948 to 1958. He was deputy prosecuting attorney of Vanderburgh County, Ind., from 1950 to 1951. He was mayor of the city of Evansville, Ind., from 1956 to 1958. He was a member of the Wabash Valley Association, the Ohio Valley Improvement Association, Exchange Club, the Central Turners, St. Paul's Lutheran Laymen's League; director, Evansville's Future Inc.

He was married to Miss Martha Tiernan of Richmond, Ind., in June 1943, and they now have five lovely children.

The Senator was elected to the U.S. Senate on November 4, 1958.

Every American, whether poor or rich, black or white, uneducated or college trained, faces a common aging problem: How can he provide and plan for a retirement period of indeterminate length and uncertain needs? That is what this hearing is about today.

Senator, welcome to Greenwood. You honor us with your presence.

Senator Hartke. The next witness we will hear will be Mrs. Leola Williams.

STATEMENT OF MRS. LEOLA WILLIAMS, PROJECT DIRECTOR, FOOD AND NUTRITION PROGRAM FOR AGED, STAR, INC.

Mrs. WILLIAMS. Senator Hartke, members of the staff, witnesses and those who have come here today, first, let me say that it is indeed a distinctive privilege to have the Honorable Senator Hartke and his staff present in our city today. It is immeasurably rewarding to us of Star, Inc., to welcome the Honorable Senator to our premises. This day is surely a milepost on the road of Star's history and, above all, this day is a highly significant one for the aged people of our State.

I would like to present some findings and recommendations for improving the nutritional aspects of living among the aged rural poor as substantiated by research of Star, Inc.

While national attention has focused more and more on the urban elderly with the establishment of senior citizens clubs, housing projects, nursing homes, and other services rendered by local, State and Federal agencies, the rural-oriented, elderly poor remain a neglected segment of the American populace. One of the most systematically overlooked groups in service and research is the aged black.

The scanty research in this area has focused primarily upon the aged blacks residing in urban areas. As a result, little is known about the problems and adjustment of elderly blacks residing in predominantly rural areas. An overall aim of the research study by Star, Inc., through its food and nutrition for aged program is to generate hypotheses for future research with aged blacks, particularly those who are rural-oriented and who fall into the category of economically deprived.

The overall aim of the food and nutrition for the aged demonstration project is to combat poor nutrition among the aged and conduct an educational program which will promote the inclusion of improved nutrition and dietary habits into daily living patterns of the participants. Secondary objectives are to effect changes in adjustment of aged participants to old age by focusing upon cognitive and attitudinal changes which will engender improved social integration in family and community and enhance conception of self-image-boosting morale and life satisfaction.

For the past 15 months, the research and demonstration program on food and nutrition among the aged rural-oriented poor in the Mississippi Delta has pointed up specific problems and conditions.

In the State of Mississippi, where 62 percent of its 2,178,000 citizens are farm and rural-oriented and where poverty abounds, those persons age 65 and over often exist amid conditions of deplorable neglect and in crucial need. This group comprises approximately 8 percent of the State's population, an 8 percent that can no longer remain ignored.

In the Mississippi Delta, one of the most severe pockets of poverty in the Nation, the problems of the aged poor certainly are severe. Illiteracy abounds among the old in this sector where the entire adult education level among the poor is below fifth grade. Among the aged poor in the food and nutrition for the aged program the median level is grade 4.

Illiteracy Fraught With Contingent Problems

This illiteracy is fraught with all its contingent problems, such as the following:

1. Very low income with dependency on old age welfare assistance. Lack of education withheld these persons from jobs which would have provided social security or other adequate old age subsistance. Average income for persons over 65 in the Delta is less than $650 per year. Our own research indicates that 84 percent of the aged in the Mississippi Delta are receiving some type of public assistance.
2. Inability to utilize available community services, coupled with being easy prey to exploitation by public officials and agencies as well as private abusers.
3. Inadequate housing is another problem. In the Mississippi Delta where 92 percent of all housing for the poor is insufficient, the aged suffer by being forced to live in the little corners allotted them in the already overcrowded homes of relatives. While the able-bodied members of the household work, many of the aged are left to care for small children, thus perpetuating in the young their own cultural disadvantages.
4. Poor health is another problem area. Years of deprivation in education, housing, and income, with all the limitations these conditions imply, have stamped the elderly poor of the Mississippi Delta with innumerable health problems. According to the findings of the Mound Bayou Community Hospital, which gave physical examinations to FNA participants in 1968–69, some of the pressing health needs among the elderly are heart disease control, cardiovascular control, physical therapy, glaucoma identification and control, dietary control for diabetes, calcium deficiency and general nutritional control and aid. It is significant also that our research indicates the following deplorable conditions:

    (*a*) That three-fourths of the aged rural poor see a doctor less than once each 6 months:

    (*b*) That, despite this irregularity of visiting a doctor, many are spending one-third or more of their meager income on drugs and medications.

In the central delta area where more than half of all persons over age 65 are dependent entirely on welfare, the problems of health, intensified by the general low nutritional level of all the population, demand immediate attention. Lack of organized effort to furnish leadership and direction to the aged rural poor results in perpetuation of a grevious situation.

In this area, the central Mississippi Delta, the percentage of the aged is growing faster than that of other areas of the States. As the younger persons migrate to places of better employment opportunities, they leave behind the old to care for the very young. Thus, the older poor, lacking the knowledge and skill to provide their own health care, are forcing many of the very young into patterns of physical neglect.

Fragmented Services

To alleviate this cycle of health neglect, there is need of increased direction and orientation in basic nutrition among the aged rural poor. Present services are fragmented and lacking in coordination. The

rural aged live mainly in their own isolated pocket and are not even aware of what services even now are available to them. To improve their daily living patterns, their health, and that of the young in their care, this group must be brought into the mainstream of life through planned direction.

Our research indicates that one area of such direction must be given through organized nutritional programs which will devise, test, and demonstrate improved approaches, methods, and techniques to reduce poor nutrition and lack of socialization among the older rural poor. This direction, as substantiated by research in the Mississippi Delta, must be geared to achieve the following immediate purposes:

1. Provide free food for the aged poor, so that the onerous burden of merely maintaining existence can be alleviated.
2. For the elderly ambulants, establish centers for nutritional meals to be eaten in a pleasant social setting where isolation traumas may be overcome and nutrition education furthered.
3. For the disabled and shut-ins, provide daily home visits by aides to assist in food buying, in preparation and serving of meals. The able aged poor must be trained to fill these positions to the highest possible extent.
4. Provide more home health care for shut-in aged rural poor, utilizing the nonprofessional able elderly as much as possible.
5. Make nutrition education available to all the aged poor, using information and materials developed by research in teaching the aged poor.
6. Provide for transportation to community service agencies and food shopping areas, as an integral part of nutrition education.
7. Develop and encourage jobs for the able aged poor, especially in work related to and involving the aged and in work with small children.
8. Develop a community job bank for aged employables. This job bank information would be made available to all potential employers.
9. Develop producers enterprises among the aged; for example, co-ops to sell farm produce, co-ops to make and sell homemade and hand-crafted items, etc.
10. Provide individual and family counseling for personal and family adjustment, for money management, etc.
11. Provide free legal services for all aged poor.
12. Provide immediate housing for the aged poor who must have housing.
13. Help aged poor to develop community clubs of their own to make plans to help themselves in the areas of their greatest needs.

LONG-RANGE GOALS

These are the immediate needs which are only indices of long-range goals, some of which are to:

1. Establish adequate nursing and care units for aged poor.
2. Do long-range planning in housing for the aged, with goals set to provide adequate housing for the increasing number of aged rural poor.
3. Train more people to work in nursing and care units for aged poor; include the able aged in this training.
4. Establish community service centers for the aged poor in rural areas. In these centers make available the full area of services to meet

all needs of the aged poor, such as education, recreation, legal aid, health, nutrition, counseling, etc.

5. Explore the most practical means of providing transportation of aged rural poor to centers for nutrition education, for socialization and other aspects of full living.

7. Concentrate on preretirement programs for counseling rural-oriented persons.

8. Further the development of community clubs among the aged rural poor.

Our research indicates that realization of both the immediate and long-range goals that I have cited should be priorities of this Nation. Surely within the bounds of the great wealth of this Nation, with its astounding technological advances, these needs of the aged rural poor can be met and this neglected segment of our populace can have its rightful share of the abundance that is America's.

Senator HARTKE. Thank you.

We will proceed with the next witness on the panel.

STATEMENT OF EARL S. LUCAS, CENTER DIRECTOR, STAR, INC., MOUND BAYOU, MISS.

Mr. LUCAS. Mound Bayou, Miss., is unique in several aspects. It is the oldest and largest predominately black incorporated municipality in the Nation. Founded in 1887, Mound Bayou is located near the Mississippi River, halfway between Memphis, Tenn., and Vicksburg, and is thus literally the heart of the Mississippi Delta.

Our population is now over 2,500. Poverty is pervasive in this region. It is a matter of documented fact, if not publicized record, that hundreds of our older citizens suffer from the effects of malnutrition.

Mound Bayou is in Bolivar County. There exists two major medical facilities there, Mound Bayou Community Hospital and the Tufts-Delta Health Center.

From the 1960 census, there are 39,680 blacks and 18,750 whites living in the county. From the 1967 Yankelovich census, done for Tufts-Delta Health Center's target area, the following was noted:

The population of northern Bolivar County consisted of 14,025 blacks, which is about 85 percent of the population. There were approximately 2,475 whites, which constituted 15 percent of the total population.

Mound Bayou is located in the northern part of Bolivar County. According to OEO Guidelines of Poverty, 14,000 blacks were eligible for total free care at these institutions, which indicated to us the kind of poverty that the elderly and the rest of the population is involved in. This is 99 percent.

One hundred forty whites were involved in the guidelines, 1 percent of the northern section of Bolivar County.

A conservative estimate shows that in northern Bolivar County approximately 2,000 of the above number are elderly Americans.

Of this group we have 60 enrolled in Star's food and nutrition program. The average yearly income is $720. Twenty persons from this group are homeowners, 22 are tenants, and 24 live on plantations. All

except five of the houses are dilapidated. There is no Federal housing for the elderly poor in this area. Housing is a general problem in the Delta.

Three-Fourths of Aged on Welfare

The source of income for three-fourths of these aged is welfare. Approximately one-half receive welfare and social security.

A great number of people are participants in the food stamp program. Cash incomes is at an all time low for many families. A change from the surplus commodity program, which has been in effect, to a food stamp program, which requires cash, presents an extra burden to many. The cash they simply don't have. Star, Inc., provides for its participants the money to purchase food stamps. Donations from the delta ministry have made this possible.

At this point, may I say that most respondents to our food and nutrition program for the aged were eating only one meal a day before entering Star's program. This meal, according to our interviews, indicated that they did not receive a balanced, nutritional diet. A number of reasons prevented their eating a balanced diet, such as, income, lack of transportation to supermarkets, lack of facilities for preparing, lack of refrigeration for storage of perishables, health reasons, and lack of knowledge of the four basic food groups.

Since Star's establishment of a food and nutritional program, many are getting the one and only well-balanced meal of the day.

What is it like to be old and live in the delta? Picture an old, black farmer, who has worked 35 or 40 years on a plantation, now displaced because of the minimum wage law, age and health, and has no record of ever being employed. He was either a sharecropper or his wife a maid. Social security benefits, in many instances, are not available because there were never any contributions made to social security.

Picture an extremely dilapidated house, which is unfit for human occupancy because of the income level. If the house is owned by the white landowner, it may look even worse because the landowner feels no responsibility for the upkeep of houses of former helpers. These people are no longer necessary to his economic gain.

I feel that no single program will ever meet the needs of the elderly poor unless it involves the total person and is geared toward meeting the needs of all his encounters.

We must meet the needs of our aged. Let us not treat his medical problems, then send him back into the environment that caused the original illness without checking that environment and helping to alleviate some of the causes of this illness.

Thank you.

STATEMENT OF MSGR. ROLAND T. WINEL

Monsignor Winel. I wish to address myself to the issue of "older Americans in rural areas" as a parish priest, which I have been most of the 30 years of my ministry and in the capacity of an associate in the Star program of Mississippi, a statewide antipoverty program sponsored by the Catholic diocese of Natchez-Jackson; as a clergyman who has served folks in rural sections of Ohio and Mississippi; as an

observer who sees there are general conditions affecting elderly people everywhere and some of the specifics pertinent to the delta of Mississippi.

This is a many-faceted problem which has concerned, I am sure, very greatly, the Senate Special Committee on Aging. However, there are four which I wish to discuss briefly.

I am sure, if carefully analyzed, there are priorities of importance in the loneliness, housing, medical care, and the dietary needs of old folks. For our purpose here this afternoon I see no need of making that distinction in my presentation.

I am not delineating here between the healthy aged and the handicapped aged. There is no question that physical and psychological handicaps only aggravate an already distressing situation.

Loneliness Indigenous to Old Age

It is the rare elderly person who does not suffer the feeling of loneliness. Social status, economic security, racial or cultural background do not exempt old folks from this experience which is almost indiginous to old age. If that is the cáse, then let us pass on to the next consideration. There is nothing we can do about changing something which cannot be changed. Here I say: Not so fast. We may not be able to change a condition existing in the aged, but we can do a great deal in lessening the suffering attached to loneliness.

Much has been done by social service agencies in providing such programs as home visiting, golden age clubs and similar activities. But you who are at all acquainted with these programs know they are found almost exclusively in large metropolitan areas. Social services and the training of volunteer workers could accomplish amazing results in relieving much of the needless sadness in the lives of our elderly people—along Avenue "I" here in Greenwood, the scattered shacks facing highways which border our plantations, and in great numbers of rural communities and farms.

Housing Acute

I mention housing. Housing is acute everywhere. And naturally, you will expect me to say there is no place where it is so acute and has been so acute as in the delta area of Mississippi. There are people who don't like to talk about our desperately poor housing. But it is a fact. Any of us here who now reside in the delta can take any visitor who comes to us and visit any community and observe the miserable conditions under which persons like ourselves are expected to live, we expect them to be healthy and we expect them to grow in what we consider to be basic human values. What do old folks do in a situation like this? They grow older and die.

Is the answer to be found in giving these good people better and larger homes for the aged? I think not. Better homes, yes. This is not an observation relative to the delta area alone. I believe this is a recognizable trend in care of the aged everywhere in the United States.

Perhaps, the rebuilding of the Camille stricken area will provide us with some directions for the future. Here again, I would strongly urge that some pilot programs of housing for the aged be considered seriously while the rehabilitation of the "10 counties"—as we have come to know the battered gulf coast—is in the planning stages.

There are a number of national and local programs providing a variety of medical services for the aged. There is no need to evaluate their merits in this hearing. There are public health nurses in this Nation's program of medical care for its citizens. But again, is this not a service which is fairly well confined to large cities? There is no public health service in small communities and rural areas—or, if there is such a service, it is so understaffed and so underfunded as to be ineffective.

There are some professionally trained health personnel in the delta. However, volunteer workers who visit the home of the aged sick poor are mainly the persons giving some kind of health care. It is unprofessional and cannot be wholly efficient. This may sound high-handed and said with a tone of professionalism. I would immediately deny any such implication. What I am saying is this: The aged who are sick and have the misfortune of being poor must have access to needed medical care. This may not mean hospitalization. It may mean, however, some kind of technical service which only a trained person can give. The cost and availability of a physician would be impossible for a person in these circumstances. Could not public health nursing be made attractive so that people in this profession would want to serve the poor sick? Could not public health programs be devised to train nonprofessional people who would be capable of rendering normal medical care to the indigent?

Older folks are notorious for neglecting good dietary habits. Again, this is a condition of living to be observed in most elderly people. Meals-On-Wheels have been provided in some cities. There are food nutrition programs such as you have observed working here in Greenwood, Mound Bayou, and Yazoo City as an experimental project of Star and funded by Health, Education, and Welfare Department.

But are we really coming to grips with the real problem? Are old people who are poor people eating properly?

"THE VERY LONELY AMERICAN"

As I was typing this paper, I was listening to Barbara Streisand belt out: "People who need people are the luckiest people in the world." Perhaps, that is a clue to some partial solution of this problem. Our Government tried a Neighborhood Youth Corps in the OEO program. Perhaps, we might try a neighborhood feeding corps.

It may seem that I have done nothing but raise problems and given few, if any, solutions. I wish to emphasize that I am presenting the facts which intimately affect the lives of the older Americans in rural areas. Where you find an older person who is a black person and a poor person, you have found "the very lonely American."

Senator HARTKE. Thank you, Monsignor.

Our next witness will be Mr. Richard A. Polk.

STATEMENT OF RICHARD A. POLK, DIRECTOR, MANPOWER AND TRAINING, AND DEPUTY DIRECTOR, STAR, INC., JACKSON, MISS.

Mr. POLK. What I will say here will amount to a summary of what has been said. Much of the presentation has been arrived at from generally related literature and private research. Some of the statements from the literature were made in 1965, and I submit to this hearing that they are just as true today as they were then.

There is a reason for that statement and that reason is the fact that the Federal Government and State governments have failed to address themselves sincerely to the program to effectively meet the needs of the poor in general, the elderly and the black poor, in particular.

As defined by the Social Security Index of 1965, 5.4 million persons past the age of 65 live in poverty. Another 1.7 million elderly persons, on the basis of their own income, would also be in the ranks of the very poor if they did not live with families above the poverty level set by the index.

Thus, of the 18 million persons past the age of 65 in the United States, more than 7 million are poor.

Age 65 is not a magic dividing line in terms of the aging and poverty—this is not a dividing line. Of those Americans between ages 55 and 64, 2.7 million persons now live in poverty. In addition, more than one-third of all poor families are headed by persons 55 and over, and more than half by persons ages 45 and over.

One out of every four families whose head is 64 and over live in poverty.

Six out of 10 older Americans who live alone are poor. They constitute more than one-half of all poor persons who live alone.

TRIPLE JEOPARDY

Senator Hartke, I welcome this opportunity to appear before you this afternoon to discuss in general the effects of being old, poor and black, not only in Mississippi, but throughout the Nation.

To be poor in Mississippi is a crime, but to be poor, black and old is triple jeopardy.

One of the great recognizable concerns of young adults is the fear of growing old, the fear of being alone, the feeling of uselessness, and probably most significant, the fear of being no longer able to provide for oneself and one's loved ones the minimum necessities of life.

It is an established fact that the difficulties to be encountered by one growing old begin to manifest themselves around age 45, because at this point work become more or even most difficult to come by.

If one expects to benefit from programs designed to benefit the black, whether old and/or poor, one must accept the well-documented fact that anticipated Government decentralization and, subsequently, more State control of the Federal dollar is not only out of tune with the tempo of Mississippi and the South but of anywhere in this Nation.

I have attached here a copy of a memorandum developed by the President of the United States, Mr. Richard Nixon. The memorandum

is related to the gulf coast situation. The memorandum directs all executive departmental heads and Government agencies to consider release of funds for any program in the State of Mississippi for the gulf coast Camille hurricane area only to the Governor of the State of Mississippi. That in itself means much to many in this room.

You are being asked to please be advised that an important emphasis in the discussion and consideration of programing, irrespective of its nobility, for any age group is that of "racial discrimination and social deprivation." I further respectfully submit that racial and age discrimination does not start south of the Mason-Dixon line, but south of the Canadian border.

The notion that discrimination is responsible for the greater incidence of poverty among nonwhites is a familiar one, and has been thoroughly documented in recent years. But discrimination also underlies the plight of the aged poor, whom our society frequently forces to retire from remunerative work before their productive capacity and willingness to work are exhausted, and whom we are prepared to assist with public money only on the condition that they do not work, or work only part time for low wages.

Now, in a more subtle way, discrimination against the aged is involved in one of the important causes of aged poverty, and that is destruction of the real purchasing power of people's savings by inflation. In allowing unions and corporations to raise wages and prices, we sacrifice the economic interest of past participants in the productive process of those of present participants.

The treatment of old people in America, many of whom have a hard life behind them, is remarkable. They and their families, insofar as they have any, now represent one-fourth of all poor people in America, a proportion that, if things are left as they are, will be increasing as their portion of the total population rises.

Poor Are Black and Black Are Poor

Let us be more specific. Leflore County is typical of the delta and Mississippi. "The poor are black and the black are poor." The average adult Leflore County black man and woman had, according to the 1960 census, 5 years of school. It is important to remember that this schooling took place before *Brown* v. *Board of Education*.

The black people of Leflore County and Mississippi grew up in a separate and very unequal educational system in the early and mid 20th century before Brown made the delta try "separate but equal" more seriously.

The result of the educational "process" is that the black and the old were never equipped for the modern economy. Less than one-third of Leflore County adult black people, by the 1960 census, worked as much as 50 weeks in a year. Family income is so low it is hard to call it income: 35 percent of the black families had income under $1,000 in 1960; 33 percent under $2,000 a year; there were 2,065 black families and 240 white under $1,000; 1,975 black families and 391 white families earning $1,000 to $2,000; there were 21 black families and 552 white families earning over $10,000.

Now, if you will, simply translate that for the elderly, and remem-

ber that the work that the State educated them to do was seasonal cotton farming as sharecroppers, or more often laborers—and that work has disappeared with mechanization and the minimum wage.

Economic Slavery

The State consciously kept the black people prepared for economic dependence, economic slavery—and now when work is scarce the older black is again the victim.

Now, what is available for help in this situation? Social security? Very, very few are covered by social security.

Welfare? Mississippi welfare allots a maximum of $60 a month to cover a family's every need: rent, clothes, medicine, and food. That is $2 a day. It actually comes to around $720 a year. Now, Mississippi is not to blame for this entirely because the Federal Government allows this and, in fact, supports it, and pays the lion's share of the welfare budget.

Nursing homes? Let us take a location in Mississippi called Jackson. Jackson is Mississippi's most urban area, and it is the State capital. It has 13 nursing homes, one black and 12 white, as categorized by one white worker in a so-called white home to whom we talked. Only the black and one other home have more than one black person. There are approximately 250 strictly segregated beds receiving State and Federal money for having signed token paper civil rights compliances.

A Last Voice

Legal services? Charity doesn't take a person far in court, and there is only one legal service program in the "poorest State in the Nation." Fraud, crooked sales contracts, lost land, lost benefits, and a lost voice. That is the lot of the poor, the old, the black and, further, the unrepresented black of all age groups in Mississippi.

Now, let us consider some possible solutions—and I want to reemphasize "possible solutions":

1. Food.
2. Shelter—and the kind of shelter to which I refer is senior citizen building grants and not loans.
3. Health. There is a need for guaranteed complete medical coverage for cases such as cancer. There is a need for staffed professional nurses to make regular visits to home of elderly.
4. Jobs.
5. Service programs. Jobs and service programs are needed here. Jobs and service programs can be used to reduce human vegetation. The service programs can provide such opportunities as central purchasing and payment of bills, transportation, programed recreation, et cetera. Establishing inter and intra community communication links to reduce the absence of companionship without removal from the sentimental setting and attachment of actual community living. The community service program is a program that can be operated and administered by the elderly themselves. This would provide jobs and income for the elderly, and it would provide a very necessary service and reduce the cost to the less fortunate in the elderly category.

6. Legal aid. There is a need for legal aid—massive legal aid—and this does not mean legal aid sponsored, administered and controlled by the Mississippi Bar Association.

7. Reduction of age requirement for being eligible for retirement benefits to age 55. This should be done on the basis of the established age expectancy by sex and by race.

A review of the literature reveals that the age expectancy for a white woman is greater than a white man; that the age expectancy for a white man is greater than for the black woman, and the age expectancy for the three of them is considerably greater than that of the black man, but yet the retirement age is the same for both.

8. Public policy, as embodied in the Economic Opportunity Act, can assist the process of reducing poverty by taking care of those who are too old or too inconveniently situated to make the upward move out of poverty, and to compensate those of the retired who are likely to be impoverished by the inflationary consequences of the shift to a tight market for labor.

9. This is probably the most important—that programs for the aged be operated by broadly based nonprofit community corporations and not by old line State and Federal agencies.

I respectfully submit that to decentralize Government funding to bring about more State government control at the exclusion of those for whom the programs are designed is definitely not the answer for programs in Mississippi.

A review of the related literature reveals that in Sweden all persons over 67 are guaranteed an income which shall amount to two-thirds of what they earned in their "productive" years.

That the age limit could be placed so high is explained first by the fact that there is a more accomplished system of social security for the sick, the invalid, and other need groups. I wish to emphasize that in the full-employment economy, old people find a demand for their labor.

The United States is equally rich as Sweden, and they could certainly afford to be more generous to the old generation.

Finally, Senator, I urge your immediate attention to the content of this hearing because I, too, hope to reach that old age category, as sure as you are born. I thank you.

The Half-Sighted Society

Senator Hartke. I want to thank all the members of the panel.

Let me ask you some specific questions. First, you raised some very interesting points to us. Points which I think are going to be very helpful.

The severity of the situation, has never been brought to the attention of the Nation, let alone to the attention of the people in authority.

It seems that a lot of people only want to see what they like to see. At present we live in a half-sighted society.

In regard to the meals here; how many meals do you provide a day?

Mrs. Williams. We provide one hot meal a day. That gives one-third the daily nutrient requirement for the participant. This is all that we are able to do with the funding that we have.

Senator HARTKE. How much funding do you have here?

Mrs. WILLIAMS. For the entire program, which operates in three cities, Greenville, Greenwood, and Mound Bayou, our appropriation for this year was $84,000.

Senator HARTKE. Did you get any help from the State whatsoever?

Mrs. WILLIAMS. No.

Senator HARTKE. Or any other Government agency?

Mrs. WILLIAMS. No; our entire funding is from the Administration on Aging under the Health, Education, and Welfare Department.

Senator HARTKE. Is that grant to be extended? When does it run out?

Mrs. WILLIAMS. It runs out June 24, 1970, and it depends on the evaluation process whether or not we go 1 more year.

Senator HARTKE. You provide one meal a day. Now, to how many do you serve?

Mrs. WILLIAMS. Our research program in nutrition is funded to provide one balanced meal daily for 50 aged persons at each of three sites. This meal provides at least one-third the daily nutrient requirement for each aged participant. We are funded for serving 50 persons daily, 5 days per week, at each of the three sites, a total of 150 per day or 750 weekly. We actually have about 70 persons at each site daily. This means we serve over 200 meals daily for 5 days a week, or approximately 1,000 means weekly.

Because we are so keenly aware of and so deeply concerned about the nutritional needs of the aged poor, we accept the additional persons, even though it means stretching the budget considerably. To effectuate this program last year, we had funds of approximately $84,000 for all expenses—food; salaries for staff, transportation for participants; supplies and equipment for three kitchens and dining halls; equipment and supplies for three offices; materials for teaching nutrition education; materials for recreation, arts and crafts; consultant fees; research data collection and computerizing, and numerous other incidentals.

Within our budgetary limitations, our research in nutrition for the aged could not have been accomplished. We have been given kitchen and dining space and equipment. Also much of the research and work done have been augmented by volunteer help and gifts from private donors.

Senator HARTKE. How many days a week?

Mrs. WILLIAMS. Five days a week.

Senator HARTKE. They go hungry on Saturday and Sunday?

Mrs. WILLIAMS. It looks like that; right.

Mr. LUCAS. It is important for us to point out to you that the program is a research and demonstration program, and they are not advocating feeding people just for the sake of feeding. We recognize this need for food, and it may be the only avenue to get the food to them, and this is why we are concerned.

Mrs. WILLIAMS. We do have a commitment for certain research that we are endeavoring to find out in regard to nutrition through this program. It is not a service program at all.

Senator HARTKE. How much do they pay for it?

Mrs. WILLIAMS. Ten cents. The meals run about 50 cents. The Government supports 40 cents of the cost, and the participant pays 10 cents.

Senator HARTKE. What if they don't have 10 cents.

Mrs. WILLIAMS. This is where the donation comes in. As Mr. Lucas pointed out, we receive private funding. We have persons we ask to help out who pay the 10 cents. Some of our participants don't have that 10 cents, and they are supported by private persons.

Senator HARTKE. What if they are physically unable to come to the central location?

TRANSPORTATION FOR INFIRM

Mrs. WILLIAMS. I am sure the Senator understands how these demonstration projects are set up. We originally, in our projection, thought that we would have people walking to the site. This proved impossible. Through an additional request to the Administration on Aging, we were able to provide transportation. Now we bring the people in because too many of them just physically are unable to walk to the site.

Senator HARTKE. Now, tell me, what is a typical meal?

Mrs. WILLIAMS. Well, it comprises the four basic foods. We can't say a "typical" meal because we have to take into consideration all of the dietary requirements for the diabetics, the cardiovasculars, and so forth.

For instance, the meal today that some of the Senator's aides observed was a meal with chicken, garden salad, mashed potatoes. Now, those who are diabetics get other substitutes. For instance, green peas or some other foods.

Senator HARTKE. You didn't put on a special meal just because the staff was here, did you?

Mrs. WILLIAMS. Certainly not. [Laughter.]

Senator HARTKE. But when the minister comes or the monsignor comes in, you put on something a little extra to make it look good?

Mrs. WILLIAMS. No; I don't do this.

But this generally is the meal, with a beverage, according to the needs of the person.

Senator HARTKE. How many would you like to see fed? What is the need?

Mrs. WILLIAMS. It would be impossible for us here, at any one site, to fulfill the need.

As I pointed out in my testimony, the need is for free food for all of these poor people who cannot possibly afford it. It seems to me that if we intended to meet all of the needs, we would have to put up a public lunch system like the public school system. We can't possibly provide for all the people who need to be fed with the facilities we have.

There are thousands of old people in this county that our research shows certainly are in need of better nutrition through provisions of the meals and through education. The need is stupendous.

FOOD STAMP PROBLEMS

Senator HARTKE. What about food stamps? How many of these people have food stamps?

Mrs. WILLIAMS. A few. Of course, you are familiar with the operation of the food stamp program, but so many of our old participants

do not use food stamps for a number of reasons, some of them peculiar to the operations in this region and some of them are the result of the way the program works.

Many of our older people feel they can't afford food stamps. This may sound shocking to someone else, but if a person has an income of $35 or $40 a month and he is asked to pay $14 to get $20 worth of food stamps, that person just feels he can't afford it, and it becomes too much. And this is true of many of the aged poor.

Then, also, the food stamp offices are usually too far away for the rural poor, and they can't get to them. There is no transportation.

As you probably know by now, transportation is one of the biggest problems. The people cannot get to the food stamp offices and the food stamps are issued at specific times. You either get it or you don't get it, and this provides another difficulty.

The office here that a number of our participants must go to is located way out by the county prison farm. We here at Star have done a job of making transportation available, but this is just a service that we provide, and it is provided by our own individuals doing this.

These are some of the problems that have resulted from the food stamps for the aged poor and the rural poor.

Senator HARTKE. We hear that quote frequently about the food stamp program.

OEO A DEMONSTRATION OPERATION

Monsignor, there is some talk of taking OEO and making it nothing more than a demonstration operation. In other words, it will cease to exist as a service agency. What do you think will happen here? What is the prospect?

Monsignor WINEL. As you know, Star has incorporated quite a bit into its operation, whether it be adult education, local centers, or the development of manpower training, food nutrition or whatever might be helpful to the local communities.

Already—just in this present year with a decrease in the funding process through OEO, we found that the adult education program cannot expand; it must be cut back.

Senator HARTKE. Let me say a word about that adult education program. That was created by a Hartke amendment. I wrote that law and passed it. I just want you to know that.

Monsignor WINEL. I think if you started something rather than expanded it, you would be highly congratulated. Not only can we not expand, but in the last month we have had to cut back.

You have heard Mrs. Williams speak about one of the basic needs in Mississippi, along with the poor and the poor black, which is illiteracy and overcoming it. We cannot do it until we overcome it at this level. We must have people who are capable, and in large numbers cooperating in these areas.

Second, you have listened to Mr. Polk who heads up the manpower program for Star. In fact, it is amazing to see how slowly Star began to make a real strong rapport with industry and business throughout the State. Now industry and business comes and says, would you train people? We can't do it.

Now, if OEO's funds are cut 15 percent this year, and we understand this is going to be the gradual deteriorating process, what is going to

happen? This isn't a matter where you are going to prevent programs from developing, but the good that has actually come to the people who are working where they were not working before, who were upgraded where they were just menial workers before, this is going to cease, and it is going to be a huge change, whether there is or not an ongoing and viable program that will make these particular projects possible. I think this will be a huge mistake.

Senator HARTKE. One thing that struck me was the fact that you said that the income here was at the lowest level.

Mrs. WILLIAMS. That was among our aged participants.

Senator HARTKE. I suppose you have heard of the SST, this supersonic transport plane. It is going to cost $1 billion. It just occurred to me that you could have 50,000 Star programs in the United States of America for the cost and the development of that plane which will take some of our fine, high-powered executives 2 hours faster across the ocean.

Monsignor WINEL. Frankly, Senator, it is a little hard for a few of us to be engaged in programs like this and not read those things without some resentment.

DECLARATION OF INDEPENDENCE FROM POVERTY

Senator HARTKE. I can see that, and I think it is true. In 1976, we will celebrate the 200th anniversary of the Declaration of Independence. I think it would be a wonderful thing if we set our goals as we did when we said we were going to the moon, set our goals for the 200th anniversary for we will make a declaration of independence from poverty for older people.

Monsignor WINEL. I hope you mean that frequently, Senator.

Senator HARTKE. We will try.

Referring to social security payments, how many people in this audience are over 65? [Showing of hands.]

Now, then, how many of you are drawing social security? [Showing of hands.]

We are going to come back to some specific questions in a moment, but we also hear talk about the fact that there is to be an increase of 15 percent in social security. Of course, with a minimum of $55 a month, a 15-percent increase means it would still be less than $64 a month. I would think that we could provide, if we really wanted to help old people, at least $100 a month minimum social security, which would alleviate a lot of the problems.

Mr. POLK. May I comment on that, and at the same time incorporate some comments of the question that was asked of the Monsignor in regard to OEO and its eventual dissolution.

I think, first of all, to reduce the programing and to change the intent of the OEO would be a serious and grave mistake. If you spin off those programs from OEO to the old agencies, most of the very talented OEO personnel, will leave Government and this will be a tremendous loss. As such, it is inevitable considering the philosophy of the administration that the State will be given more control over these programs.

I am also glad to know that you have structured the bill for adult education. I am sure that in all sincerity you will put forth every

effort to assure us that the adult education program will not spinoff into the hands of people who control the State department of education.

Finally, the Office of Economic Opportunity was intended as an agency to fund only demonstration and experimental progams, and eventually to spin operational functions off to local and State agencies. It wasn't long before it was made very clear that the time in Mississippi and the time in this Nation was not just right for such spinoff, and I say to you that the time for such spinoff is not now right.

The OEO has given, particularly, the black people the only opportunity to exert a voice in the decisionmaking process as affect programs designed for them, and programs to determine the destiny of their lives. If this is done I fail to see how any other old line agency or State agency will give the same opportunity to operate in the same manner as the Office of Economic Opportunity.

Now, the State of Mississippi at this very moment is receiving "We Care" funds from across the Nation in an amount that no one in the public has been able to note or discover, and as to the disbursement of those funds, there is not a single black person participating on the committee. There is not a black person on the gulf coast who participates in the decisionmaking process of that area, and I submit to you that that is an excellent example that the time is not right.

Senator HARTKE. Mr. Polk, are you speaking about hurricane relief or general relief?

Mr. POLK. I am speaking of hurricane relief, to illustrate my point against total decentralization.

MINIMUM WAGE AN EVIL?

Senator HARTKE. One thing that was raised by two different participants here was this question of minimum wage, an effective minimum wage. I understand from what you said that the minimum wage bill has had the effect of excluding certain people from the labor market. Isn't that the effect of it? How do you look upon the minimum wage bill? Is it an evil?

Mr. LUCAS. No, it is not an evil. It just meant that a large number of black people were displaced from plantations, and whatnot, because they weren't going to pay a minimum wage. It just increased, you might say, a hurried mechanization to those operations because they no longer needed them.

Senator HARTKE. How many people here do you believe participated in the Medicaid program and Medicare—Medicaid, especially; that is, where they made a contribution?

Mr. LUCAS. I don't know. We don't have it here.

Senator HARTKE. You don't have any Medicaid in Mississippi?

Mr. LUCAS. None.

Senator HARTKE. You don't have any Medicaid?

Mr. POLK. The State just passed a totally inadequate Medicaid measure and the essence of what has been passed is that there is none.

Senator HARTKE. Maybe we could help some. Maybe we could alleviate some of that problem and provide three things which are necessary for old people—hearing aids, eye glasses, and false teeth. If we could give them those three things, that would certainly help.

One other thing, are there any public housing projects for the aged here in Greenwood? Any at all?

Mrs. WILLIAMS. No.

Senator HARTKE. Why not? Mayor, I think it is all your fault. You have been in office 3 months and haven't done a thing. [Laughter.]

No, I can't blame you. But why not?

Monsignor WINEL. To the mayor's credit he has just established the public housing authority.

Mrs. WILLIAMS. There has been none before Mayor Henry came to office.

Senator HARTKE. I would say that if you do move forward in that program, it will be one of the most satisfying things you will ever do, not only for the mayor, but for all the people. I have found that most of these communities that have had them and run them have been proud of them, and it is really something out of this world. It is something to look forward to with a great deal of anticipation and satisfaction.

You are shaking your head at me. Don't you have enough money?

Mr. HENRY. No.

Senator HARTKE. Could you do it on a grant basis?

Mr. HENRY. Yes.

Senator HARTKE. But not on a matching basis?

Mr. HENRY. No.

Mr. LUCAS. There is another way. They usually allot an original development area, and in that area an area is disbursed for housing to the community.

Senator HARTKE. I am talking about housing for the aged and that is not necessarily true.

I know we are talking about money. You mentioned free food, but I think most people who are old are really not afraid of dying. They are afraid of loneliness, and they are afraid of things that happen to them while they are living, and insecurity. But I hope that you will keep your eye on one factor which I think is very important. Most people would rather pay for their food than to have it given to them free. They would rather pay for it themselves. This leads me to the social security question.

We could make a big step forward by increasing that social security to $100 a month. That money could go right straight to the person. He could make up his mind how to use it, even if he uses it wrong. I would rather have the people make some mistakes rather than have the bureaucrats telling them they should not make any mistakes.

We will now excuse this panel of witnesses and proceed on to our next panel.

STATEMENTS OF MRS. ANNIE LOTT, GREENWOOD, MISS.; MRS. OPHELIA HENRY, GREENWOOD, MISS.; MRS. ELIZA GOSA, GREENWOOD, MISS.; AND MRS. ELDER LEANNA BROWN, GREENVILLE, MISS.

Mrs. WILLIAMS. We are going to continue with these witnesses, our own senior citizens. Our citizens are simply here to answer your questions. They would like to have you direct any questions you have to them.

Senator HARKE. We will start on this end.
How old are you?
Mrs. HENRY. Sixty-three.
Senator HARTKE. And are you married?
Mrs. HENRY. I have been married.
Senator HARTKE. Where do you live?
Mrs. HENRY. I live in Greenwood.
Senator HARTKE. Do you live with anyone?
Mrs. HENRY. I live alone.
Senator HARTKE. Do you have any money that comes in every month?
Mrs. HENRY. Welfare.
Senator HARTKE. How much do you get a month on welfare?
Mrs. HENRY. $54.
Senator HARTKE. Do you have to pay rent out of that?
Mrs. HENRY. That is right.
Senator HARTKE. How much is your rent?
Mrs. HENRY. $7 a week.
Senator HARTKE. So that is about $30 a month, is that right?
Mrs. HENRY. Well, according to how the weeks run. It could be $35 sometimes, or $28.
Senator HARTKE. Do you have to pay anything else as far as any utilities?
Mrs. HENRY. Yes, gas, water, and lights.
Senator HARTKE. Do you have to pay that?
Mrs. HENRY. Yes.
Senator HARTKE. How much is that?
Mrs. HENRY. I can't remember since that last time, but it has been at times $10 and $11.
Senator HARTKE. Do you work any place at all?
Mrs. HENRY. Nowhere.
Senator HARTKE. What do you do for food, then? That leaves you very little money for food.
Mrs. WILLIAMS. She has hearing trouble, and here again that hearing aid business would help.
Mrs. HENRY. Well, I do the best I can. I get those food stamps, and last month I had to pay half. That was $18.
Mrs. WILLIAMS. To get how much?
Mrs. HENRY. To get $23 worth.
Senator HARTKE. Does that help you?
Mrs. HENRY. It helps me some, but not all the way through.
Senator HARTKE. Are you on social security at all?
Mrs. HENRY. No.
Senator HARTKE. You don't draw any social security?
Mrs. HENRY. No, but I wish I did.
Senator HARTKE. What do you do when you get sick?

"DO THE BEST I CAN"

Mrs. HENRY. Well, I just do the best I can.
Senator HARTKE. Do you get a doctor?
Mrs. HENRY. Well, I just do the best I can, and go to the doctor, and my medicine would be about $8 or $9. I don't have enough money to meet all of my needs.

Senator HARTKE. Do you eat here at all?
Mrs. HENRY. I do.
Senator HARTKE. How is the food?
Mrs. HENRY. It is fine.
Senator HARTKE. How do you pass the time away during the day? What do you do during the day?
Mrs. HENRY. I clean up around the house, and cook when I am home and when I am able to.
Senator HARTKE. Thank you.
Mrs. Lott, how old are you?
Mrs. LOTT. Sixty-eight.
Senator HARTKE. Are you on social security?
Mrs. LOTT. Yes, sir.
Senator HARTKE. How much do you get a month?
Mrs. LOTT. $51.
Senator HARTKE. And who lives with you?
Mrs. LOTT. Nobody but my husband.
Senator HARTKE. Does he draw social security?
Mrs. LOTT. Yes, sir.
Senator HARTKE. How much does he get?
Mrs. LOTT. Same thing.
Senator HARTKE. Is that enough get by on?
Mrs. LOTT. No, sir, my husband is dying of cancer.
Senator HARTKE. Do you have to take him to the doctor?
Mrs. LOTT. Yes, sir, we take him about two or three or four times a month—three anyway. He is in bad shape.
Senator HARTKE. How much is the doctor bill?
Mrs. LOTT. I don't know, sir. It is just high. He has to pay for his medicine. About $5 or $6 to examine him and maybe $8 a time for medicine.
Senator HARTKE. How much is your rent?
Mrs. LOTT. $20.
Santor HARTKE. Do you have to pay utilities in addition to that?
Mrs. LOTT. All of that.
Senator HARTKE. Are you on Medicare?
Mrs. LOTT. Yes.
Senator HARTKE. Does that help you?
Mrs. LOTT. Well, it helps a little. I was operated on a year or two ago, and my husband has been hospitalized twice lately. They pay some of it, and he has to pay the doctor bill. They pay some part on the Medicare.
Senator HARTKE. So it helps some?
Mrs. LOTT. Yes, I can't help to say but that it helps a little.
Senator HARTKE. What do you do during the day?
Mrs. LOTT. Like they say, just piddle around because I have got heart trouble and arthritis and high blood pressure. We are both in bad shape.
Senator HARTKE. Do you eat here?
Mrs. LOTT. Yes, sir.
Senator HARTKE. Both of you eat here?
Mrs. LOTT. He doesn't. He eats here sometimes. His doctor bills are too high. He doesn't eat here every day, but I eat here regularly.
Senator HARTKE. Do you want to keep the program going?

48-387—70—pt. 5——4

Mrs. LOTT. This program?
Senator HARTKE. Yes.
Mrs. LOTT. Lord, yes. I don't know what I would do without it.
Senator HARTKE. Do you get any money from welfare, in addition to your social security?
Mrs. LOTT. $15.
Senator HARTKE. A month?
Mrs. LOTT. Yes, my husband and myself both, it is the same.
Senator HARTKE. Do you have any children?
Mrs. LOTT. Not at home.
Senator HARTKE. They are all gone, is that right?

CAN'T AFFORD FOOD STAMPS

Mrs. LOTT. All grown up and gone. I have been wanting to get those stamps. They would help me a whole lot, but I can't get them.
Senator HARTKE. You can't get them? Why not?
Mrs. LOTT. I have got some twice and they paid half, and I paid half, but if they don't pay half, I can't get them at all because they want me to pay $34 for $40 worth of stamps.
Senator HARTKE. You paid——
Mrs. LOTT. In money, $34 and they gave me $40 worth. They told me when I got them if I didn't have the money to get them over at Wesley Chapel. They told me to get them out at the stamp place, but I haven't got any money.
Mrs. WILLIAMS. May I interject here, Senator Hartke. When Mrs. Lott mentioned Wesley Chapel she was talking about the emergency food and medical service program that is part of the OEO which has helped provide money for some persons to buy food stamps. As she pointed out, she has not been able to get them.
Mrs. BROWN. I am very happy today because I have never seen a Senator before.
My name is Mrs. Elder Brown from Greenville, Miss. I am a widow, and I live alone at the present time. I draw $51 a month from social security of which Medicare took out $4. I have been drawing $48 welfare. I pay $35 for house rent, $10 and up for gas in the wintertime and all of the other bills included.
Senator HARTKE. Now, there is a proposal by some of the people in Washington. They say they will have to raise the amount of charges under the Medicare program. What will that do to you? Will you be able to pay another $3 or $4 a month?
Mrs. BROWN. I don't see where I would be able to pay it. I am still suffering. I pay some of the bills one month and tell the others I will be there the next month.
Senator HARTKE. You just pay the bills you can?
Mrs. BROWN. I do the best I can. And I eat in the center in Greenville.
Senator HARTKE. Does that help you a lot?
Mrs. BROWN. Just wonderful. I don't have to cook but one meal a day at home. I go there and I eats my stomach full. They really have good food down there in Greenville. I like it very much.
Senator HARTKE. Do you work at the center?
Mrs. BROWN. No, I don't work at the center.

Senator HARTKE. Would you like to do something?
Mrs. BROWN. I am 72 years old.
Senator HARTKE. You don't look it.

GLAD TO DO WHATEVER I CAN

Mrs. BROWN. But I would be glad to do whatever I can.
Senator HARTKE. How would you like it if they had some program down there to do some things?
Mrs. BROWN. I would like it very much. It would keep me happy.
Senator HARTKE. If they had a program like that, do you think a lot of people would work with you around there?
Mrs. BROWN. Well, I am always able to accompany somebody.
Senator HARTKE. Thank you.
You are not on social security, are you?
Mrs. GOSA. I tried to, but I don't have enough points. I had cataracts on my eyes and I was going blind.
Senator HARTKE. What did you do about that?
Mrs. GOSA. I went to the doctor in Memphis, and he took them off.
Senator HARTKE. Who paid the bill?
Mrs. GOSA. The Lions Club.
Senator HARTKE. The Lions Club? They do fine work. They do a lot of work in this field.
Do you live by yourself?
Mrs. GOSA. Yes.
Senator HARTKE. How much welfare do you draw?
Mrs. GOSA. $60 now.
Senator HARTKE. $60 a month?
Mrs. GOSA. Yes.
Senator HARTKE. How much is your rent?
Mrs. GOSA. $13.50.
Senator HARTKE. How much do you have to pay for utilities?
Mrs. GOSA. In the wintertime I pay $8 or $9 for lights and things.
Senator HARTKE. Do you live by yourself?
Mrs. GOSA. Yes, sir.
Senator HARTKE. Do you have any children around?
Mrs. GOSA. I have one who lives in Patterson, but he has 11 children, and he can't help me. He can't even help himself. Their baby isn't a month old. I know they can't help me.
Senator HARTKE. I can understand that.
Mrs. BROWN. I would like to say, Senator, it is a pleasure to be here, and we are enjoying the center where we are working and eating, but we have to wait on our transportation so long and we have to just sit there, so I wrote Senator Eastland to see if he would help us to get a television so that we old people could see some of the programs while sitting and waiting until our turn comes.
Mrs. GOSA. I would like to say I enjoy this program. I have been coming here about a year, and I haven't missed one day. I get more enjoyment out of that more than anything else.
Senator HARTKE. Mrs. Williams, I want to ask you one final question. The nutritional program has brought some of these people to the center?

Mrs. WILLIAMS. That is right.

Senator HARTKE. And has that program opened the door to expose some of the difficulties as well as opportunities?

Mrs. WILLIAMS. That is true. Through the nutritional program, we have gained insight into the problems of the people that we certainly did not have before, and it has provided the people with the type of socialization that many of them never have.

We can cite instances of some of our people who lived very near to town and had never gone to town in years, and also persons who hadn't been out of their yards for years. So it has provided an outreach and outgoing type of thing for the people.

It certainly helps against that isolation that you have been talking about. But, of course, as pointed out, we are very much limited because of the amount of funding. It doesn't let us do the things we want to do.

Senator HARTKE. I want to congratulate you on the fine things you are doing, and I hope we can open a few doors and make things better for some of the people.

STATEMENT OF JOHN HATCH, DIRECTOR OF COMMUNITY HEALTH ACTION, TUFTS-DELTA HEALTH CENTER, MOUND BAYOU, MISS.

Mr. HATCH. It is a pleasure to be here and to find this many people concerned with the problems of the elderly, and I would just like to say "Amen" to everything that has been said before. We know what needs to be done. It is just a matter of getting our officials to respond to this need.

I am going to talk a bit about some of the social problems in aging, and as we have seen in the Tufts-Delta Health Center in Mound Bayou.

We are increasingly aware of the concerns of senior citizens in the matters other than just physical needs and of the related needs of their social well-being and physical problems.

The center staff is presently in the progress of gathering information relating to the problems of aging in the view that it will all aid the development of more sharply focused services; more specifically, to test the validity of the friendly visitor approach as a means of identifying problems requiring immediate intervention, to collect and analyze data essential to the development of basic preventative service and to gain insight into the nature and extent of social and physical needs of residents 62 years and over, relative to comprehensive program development.

Information from these contacts is being grouped under the following headings: Level of adjustment to the social and/or physical environment; skills and capacity related to homemaking; nutritional problems; general social functions; illness and other stressful situations and/or insurance.

A major part of the work with older persons has been assumed by 10 health associations that comprise the North Bolivar Health Council. The health associations are voluntary organizations concerned with the overall welfare of persons residing in the respective service areas.

A major committee in each community is the elderly committee. Many simple but effective activities are being performed in several communities. Residents have developed a schedule for daily visits for persons living alone.

In Alligator, a group of men headed by Ben Brady have developed a volunteer task force whose specific purpose is toward improving the physical environment of older persons. Their activities include roof repair, building privies, replacing broken glass, and providing wood for fuel during the cold season.

In many ways, I feel the potential for favorable social and physical adjustment of the older rural person or smalltown person is greater than a similarly situated person in a larger urban area.

Most of the elderly in Bolivar County have been living in the same environment for many years. We know of many whose attraction to the area has caused them to reject adequate physical accommodations offered by their children now residing in better areas.

The older person who is able will be active with the church or other fraternal or social groups. He generally knows all of his neighbors and can depend upon them for a number of tasks essential to his function.

As a result of the close social relations characteristic of this reasoning, the elderly person is not as likely to experience the social isolation so common in urban settings.

There are, of course, many problems. Most of these can be satisfactorily handled if money is available. Again, the major asset, as I see it, in terms of this region's ability to cope with the problem, is the concern of people in the community. But most people in our area are poor. Resources of the able-bodied younger population are severely limited. The community does not have the resources to do those things it feels are basic to the dignity of its older population.

A random selected sampling of 50 cases on elderly persons that we have contacted produced the following information: 33 had experienced some difficulty in shopping; with 20, the major problem was transportation; 43 experienced some difficulty in home maintenance; the absence of an adequate water supply was mentioned by 19 of these persons. Eleven had no toilet facilities whatsoever. None of the toilets inspected would reach minimal standards for health. Thirteen had leaking roofs, and 30 complained of the wind blowing through. Forty-six persons considered themselves active church members, although 14 had not been in the prior 3 months, and, again, transportation was another major problem.

Thirty-one spoke of nutritional problems. Most often the rising costs of food was mentioned as a major reason. Yet, we know most do not have eating habits compatible to their less active life or to the nutritional needs of the elderly people. Of the 31, nine persons were on specially prescribed diets and had neither the money nor the transportation to acquire the foods that doctors had, in fact, prescribed.

On socialization, 18 of our sampled mentioned being very lonely at times and told of everyone moving out of the rural area. Seventeen persons experienced some difficulty in preparing meals and/or performing daily household tasks.

Given limited support, a high percentage of the population would be capable of independent function. In our opinion, the following would be rather extensive things that can be done now:

TRANSPORTATION

Few elderly people have ready access to transportation. Many live in relative isolation, often residing in a rent-free house way back in the woods off some cotton field. Although some are provided limited maintenance, the general pattern now is to abandon the shacks that were formerly plantation residences.

Scheduled transportation to town on a twice-a-week basis would offer the person an opportunity for shopping and for socialization. At the present time, we know of many elderly people who actually give up a part of their food to buy transportation to go get food stamps—those fortunate enough to buy them.

Homemaker services should be made available to provide home environmental training to the people who need it. Many do not need intensive help, but many do need help with homemaking chores.

Housing, of course, is a problem. There should be new housing for every elderly person who needs it, and it should be available now. Yet, we know that this is not likely to occur, so we have set as our goal at least minimum standards which we think are required for health: A safe water supply, a safe system of waste disposal, and a shelter that protects people from the inclement weather.

Now, in the program at the Tufts-Delta Health Center, we have tried to get money to do these things, and we felt that for $300 per household we could at least supply a safe water supply, a good privy, stop the roof from leaking, and cut down on the wind that blows in.

We were unable to get the program financed to that level that would make this possible.

The health association—and this is an indigenous people's organization that is set up in the form of a community development corporation—is interested in developing day care centers for the elderly in pretty much the style that Star has already described.

In such a setting the person would have the opportunity to socialize, secure a balanced meal, and be seen by a health official before a crisis developed.

There are, of course, some persons who will require a level of care that can best be delivered through well-conceived and operated extended care facilities. The health council would like to sponsor such a facility. However, attention to the above-stated concerns in terms of prevention would greatly reduce the level of need for institutional care.

Thank you.

Senator HARTKE. What is the general quality of health care here for these people now?

Mr. HATCH. Now, this is for the older people in this general area. The general area I couldn't discuss. We are associated with the Tufts Health Center, and we like to feel that the care for the people in the center area is excellent. We know that before we began operation in northern Bolivar County, it was extremely poor, but Dr. Weeks might best speak to that.

STATEMENT OF DAVID WEEKS, M.D., MEDICAL DIRECTOR, TUFTS-DELTA HEALTH CENTER, MOUND BAYOU, MISS.

Dr. WEEKS. This Tufts-Delta Health Center is a wholly OEO funded program for about 14,000 people in northern Bolivar County and is located in Mound Bayou, Miss.

One of our major—if not the only—goals is to provide comprehensive health care services to those 14,000 people. At the moment, to do that, we have on our staff approximately nine physicians, about eight nurses, a number of wives and these complement the eight assistant personnel. So we like to think of our medical care that is now available as outstanding. But it has a long way to go.

Also, I think I will skip part of the things I have prepared because they have been fairly well covered by the rest of the speakers.

It is widely recognized that the elderly has a greater risk of acquiring a serious, chronic, debilitating, life-threatening disease than the youth or middle-aged person, and the relation between disease and poverty is well recognized. And there is no need to comment on it further.

ELDERLY BLACKS HAVE POOREST HEALTH IN NATION

It is also well documented that the life expectancy for all age groups is shorter for the black person than the white. Other data support the fact that the black elderly have the poorest health of any single group in our Nation. For example, the black person in the South has the lowest average halometry, which is a measurement of how strong the blood is, of any group in the United States. This is especially true for the black person in the South.

The fact that a person is elderly, black, poor, and lives in the South, means that that person is at the greatest risk of having ill health, debilitating disease, and dying.

This fact is further compounded by the lack of health service for this very same population. The lack of health services has multiple detriments, and I won't try to go into all of them, but certainly two of the major ones are the lack of facilities, lack of physicians, nurses, technicians, X-ray technicians, social workers, and health workers, and this quantitative lack is intensified by the racism and lack of concern to the health profession here in Mississippi.

Therefore, it was of little surprise to us of Tufts-Delta Health Center when we provided service to 14,000 people in the rural Mississippi area that the 11 percent of the 14,000 people who were 65 constituted almost 20 percent of our clinical visits and almost 50 percent of our home visiting nurses' efforts are directed toward the elderly.

SOME CASES

Neither was it surprising that a vast amount of neglecting disease was found in these elderly patients. For example, an elderly bed-ridden man, who had not been able to receive care, was brought to our clinic weighing 327 pounds. The man was found having a massive accumulation of fluid in his body. We placed him on proper medication for a diabetic and in 3 weeks his weight dropped from 327 to 192, 135 pounds,

which was due to the loss of fluid, fluid that accumulated over a number of years.

Another elderly patient came to the clinic with several years of gradual loss of vision and pain in both eyes. She had not attained adequate care before because of the cost of the care. She was found to have glaucoma and is now completely blind. This patient's vision could have easily been saved if medical care—and not so difficult or complex medical care, but very simple medical care—would have been available to her just a few short years ago. She now lives by herself in a remote shack, living on welfare payments.

We are now providing care to a 67-year-old, partially blind woman who is fortunate to own 40 acres of land. Though partially blind and of ill-health, she is trying to make a living with 40 acres in cotton. Because she owns the 40 acres, she is not eligible for welfare payments. Because she is partially blind, ill and elderly, she cannot manage the 40 acres. Taxes have not been paid on the land, and she is in debt. It is just a matter of time before the land will be taken from her.

A 74-year-old man has recently been treated in our clinic for an obstruction of his bladder. His bladder was enormously enlarged, and he was in severe pain. He had been in that condition for several months. He lives alone in a shack in the middle of a cotton field with cotton up to his front door. He receives $60 a month welfare payments. With this, he pays rent and tries to buy sufficient food. Because he receives only $60 a month and must pay the rent, he can't afford the food stamps, as you have heard frequently today. He was admitted to the hospital, and on discharge this man would face almost insurmountable problems—not of living, but of existence.

These examples are not the exception, but all too often the rule and can be duplicated repeatedly not only in our target area but throughout the rural South.

The problem of neglected diseases in an elderly poor population scattered over a rural area with inadequate services and inadequate transportation, even if the transportation is available, is not readily solved.

However, immediate action that could be taken now would include funding for the development of community based and community operated day-care centers. Such centers provide meals, a place to socialize, and a place where supporting health services can be provided. Funding could be made available for broadening support of existing day-care facilities.

The State of Mississippi could broaden the State welfare program.

A fund could be provided for a pilot system, a system whereby the young, black, and rural youth could enter the health and related professions.

Further, the Federal Government must, through a variety of agencies, make every effort to provide comprehensive health services to the elderly and rural population in Mississippi.

Thank you.

Senator HARTKE. Do you feel that your program is going to continue, or are you going to be cut back, or what is going to happen to your program?

Dr. WEEKS. My general feeling, not based on any fact, but on feeling, is that it looks fairly secure for a year or so.

I think that is about as far as I could say.

Senator HARTKE. You have made substantial progress?

Dr. WEEKS. Yes, I think we have made some real progress.

Senator HARTKE. But the problems are beyond you in their totality?

Dr. WEEKS. Yes, that is part of it. And I think the thing that is very disturbing is that we are only dealing with one small program in terms of total population.

(Additional information in appendix 1, page 367.)

Senator HARTKE. I can see that quite easily.

I think that we will proceed. We do have a number of witnesses here, and we will try to move right along.

STATEMENT OF GENEVIEVE FEYEN, R.N., JACKSON, MISS.

Miss FEYEN. I am happy to be here today to speak for my many elderly friends of Greenwood and Leflore Counties with whom I had the pleasure of living and working for 14 years. I am very proud to be able to speak for these people whose needs are so many and who ask so little, but who have given so much throughout their years.

Before I start, I would like to second what Dr. Weeks said, that the problems that he mentioned health-wise are more the rule than the exception around here. We certainly have problems.

In your letter, Senator Hartke, you stated the objectives of this committee study, and I will try to address my statements to these points.

The first objective is to explore the unique problems encountered by those elderly who live in rural areas, including economic or other pressures that may cause withdrawal from such areas.

To describe the economic conditions of the aged in our area is difficult in that you hardly know where to begin. In any area of our community you can easily see the appalling exterior conditions of the home.

1. Two- or three-room "shotgun houses"—which means that you can shoot a gun in the front door and it can go out of the back and kill everybody on the way.

2. Very basic plumbing in some homes consisting of one toilet and one sink, sometimes not in working order.

3. On the plantations and even in some homes in the city itself:

(*a*) No plumbing.

(*b*) Outside toilet.

(*c*) Outdoor water faucet for anywhere from one to six houses.

(*d*) No sewage—wastes thrown out the back door.

(*e*) Few bathtubs; showers are virtually unheard of.

(*f*) People must carry water, heat it and bathe in an old-fashioned tin tub. One family I know gets the water for cooking and drinking from the "big house" (plantation owner's home) about three blocks away each morning.

The children have to go get the water, and the water has to be rationed so that "we don't have to bother the boss man so much." Water for washing is obtained from a pond in the yard, full of Mississippi mud.

All this lifting and carrying or "toting" as we call it here, is not the healthiest or most comfortable for the aged with their common problems of rheumatism, arthritis, heart conditions, and hypertension.

Outside stairs and porch often are very hazardous and in a state of disrepair. Older people have told me they are sometimes afraid to come out of the house for fear they will fall.

Leaking roofs, cracks and holes in walls and floors are common. Many homes have newspaper and magazine pictures which serve a dual purpose, warmth and decoration.

Screens have holes or are missing completely.

Some homes have gas, space heaters, but most rural homes retain the use of wood stoves or old fireplaces which adds to the tedious job of gathering kindling.

In a masters study in nursing, done in this area in 1966, 145 senior citizens living in substandard housing were interviewed as to the problems related to housing. The most common problem mentioned was that the dwellings were "cold;" predisposing to pneumonias, arthritic pains, asthma, and numerous other diseases.

Oil lamps are often seen. If electricity is present there is usually one outlet per room and it is generally overloaded.

In our rainy winter season, boards serve as sidewalks to and from the homes, isolating older, arthritic people, who try to balance on these boards.

Of course, mice and rats we have always with us. Dancing on the ceilings and boldly racing around the rooms. Many times while caring for patients, I would have to keep moving my feet to keep the rats from running over them.

Roaches Own the Houses

Roaches own the houses and just allow the people to stay there.

These are the most obvious conditions seen time after time as I visited the aged in our rural county. The saddest part is that the people are proud of their homes and if they had any money to spare, they would use it to improve them. But the best most can do is to put up a picture or plant some flowers.

If this paints a sad picture——

Senator Hartke. Wait a minute. You are painting this picture. What if somebody asked you, let us move you to the city, would you paint a bleak picture?

Miss Feyen. It is just as bleak in the city as in the rural area.

Senator Hartke. What if you move them to a senior citizens housing project? Would they move?

Miss Feyen. I believe they would, if they had sunshine and grass and friendly people running it, depending on who asked them.

Senator Hartke. I think it is a very important question. We run into it frequently where the people say they won't move. They don't want to go. They have been living there all of their lives.

Miss Feyen. I believe they would, if there were enough sunshine and air and if the people who ran it had an interest in them.

Senator Hartke. What if they moved to mobile homes which do

not have some of these deficiencies you are talking about. They would have indoor plumbing and showers and——

Miss FEYEN. They would be in one central location?

Senator HARTKE. Yes, in one central location.

Miss FEYEN. If they knew the right people who were interested in them and were friendly and concerned about them.

Senator HARTKE. Now, we are not going to change human nature. We are not going to go that far. We are just talking about the houses, the physical facilities. If you would provide them with a decent home, would they desire to move and would they like to move into an apartment-type complex or would they insist on having individual units?

Miss FEYEN. I would say they would like individual homes rather than apartments.

Senator HARTKE. But almost anything is better than what they have; isn't that right?

Miss FEYEN. Yes.

Now, if this paints a sad picture, it is nothing compared to the constant struggle to pay rent, food, and medical bills out of their small checks of $55 to $65 a month.

NUTRITION A GREAT HEALTH PROBLEM

Nutrition is a great health problem among the aged in our area. They have lived most of their lives on Government commodity foods, leaving them oftentimes anemic and undernourished. Now, the food stamp program has replaced the commodity program, but still many problems exist.

1. The cost remains too high, with bonus stamps too low.
2. People can buy commodity type foods cheaper than the stamps.
3. The aged, in particular, are not educated to the value of a well-balanced, nutritious diet.

The food program offered to the elderly by Star, Inc., in this area is an excellent program, but constant education and continual follow-up, particularly in the home, is essential.

A few examples in that area are:

1. An elderly hypertensive patient, approximately 68 years, on a low salt diet, ate breakfast at the center, then went home and fried some pork chops saying, "I always eat meat for breakfast."
2. Another patient, a diabetic, about 70, would religiously eat diabetic canned peaches because she had them on her tray at the hospital, but when I found a half of a watermelon in her icebox, she stated that she had eaten the other half the day before and would finish the rest of it that day. She saw nothing wrong with this because watermelon was on her "diet list."
3. Another man, a hypertensive on a low salt diet, after stating that he did not eat any salt or salty foods, proceeded to take a bag of potato chips out of his pocket and eat them without connecting salt and potato chips at all.

I could go on and on with example after example of the problems encountered in following regular diets and the prescribed diets so frequently needed by the elderly. But let me again state that the inability to pay for the right foods and the lack of knowledge of the right foods greatly affect the general help picture of the aged.

The "Choice"—Food or Medical Care

The astronomical cost of medical care and the availability of medical care brings us to the second of this committee's objectives—to determine whether Federal programs and services intended to serve older Americans are as effective as they should be in rural areas.

Throughout the many past years, black people of our area have had to weigh carefully their decision to seek medical care based on money which never seemed to go around. When it was a choice of rent or medical care or food or medical care the person's immediate health needs were usually the loser, causing a situation now where many chronic and serious diseases are present in most of the elderly citizens.

Only great pain or inability to work would preempt other needs when it came to spending that precious pitiful check. Thus hypertension, so common here, would not be treated until it caused headaches, dizzy spells or "falling out," or making blood presures of the 200+/120+ common and ordinary. I have known frequent cases of blood pressures at 300, and the people are walking around.

When a condition became so severe that the decision had to be in favor of medical care, the $5 to $10 for the physicians office call was scraped together. But there was seldom enough left to buy the medicine, making the office call many times almost useless and the money gone for naught.

In defense of the doctors, I must add that many times the patients were seen with no charge or with deferred charge.

On the whole though, most senior citizens are very proud of having made their way thus far on their own and do not want to accept charity as such. Many times, I have been repaid for nursing care with cakes, pies, potted plants, or bouquets of flowers. The pride and dignity of the aged is truly an inspiration for all.

Within the last few years, the health department has conducted excellent clinics for the aged providing diagnosis, care and treatment for cardiacs, hypertensives, and diabetics—but the patients must get to the clinic as best they can. Some walk. No satellite clinics are provided so this often means a hike of 1 to 3 miles which to the aged, who have difficulty even getting around the house, is quite a task.

Some pay a neighbor to bring them longer distances, costing from $5 to $10 for the ride. On sunny, clear days it is almost impossible to find a ride as the men who own cars often drive tractors on the plantation and must work. So if it doesn't rain on the clinic day, this health service, free as it may be, is not available to many of the rural and most needy.

I know of many persons age 70 to 80 who hitchhiked into town to the physician or clinic. How degrading this must be to a person who has spent his whole life working, and working hard, on a plantation, to stand on the road and beg a ride.

Physicians' house calls are virtually unknown, particularly in the rural plantation areas where it takes time to find the home; roads are poor, almost impassable during the rainy reason when the clay roads are muddy and slippery; if medication is needed, it is again a matter of paying someone to come into town to buy it—if you have the money.

Consequently, if one is in the rural area and is too sick to ride into

town, he must either wait until he is better and can ride to town, or resign himself to dying, for no help is available.

Before incurring the expense of hospitalization, a person had to be almost dead, leaving people with the still prevalent idea that when you go to the hospital you die, which, in fact, many did.

Medicare

But then the great help to the aged, Medicare, came, leaving our community as bad off as before since the hospital was not in compliance and could not receive Federal funds. At last, this year, the hospital has built a new wing, making all rooms private rooms and thus "integrating." So we are on the first mile of educating the aged to hospital care.

The voluntary medical insurance portion of Medicare is nothing but added confusion and added expense to the very poor.

1. They cannot afford this added expense.
2. They do not see the doctor more than a few times a year.
3. They must pay the first $50, meaning almost all office visits are at cost to them, anyway.
4. They must make the initial payments after that and be reimbursed, but the problem is that they do not have the cash to make the initial payment.
5. Medicine is not included, so again, is the visit worthwhile?

This again seems to be a case of legislation aimed to help the poor, helping all but the poorest of the poor.

Under medical expenses, I have not even touched on two common everyday items to most people, but which are out of the question to the aged poor in our rural area—eyeglasses and dental care.

Senator HARTKE. Why don't you put teeth in there?

Miss FEYAN. Well, I have eyeglasses and dental care.

Senator HARTKE. Well, I would venture to put hearing aids in there as well as glasses. More people need hearing aids than need glasses. Statistics show that.

Miss FEYAN. I would say more people would wear glasses than hearing aids.

Senator HARTKE. I know, but the point is——

Miss FEYEN. They need them.

Senator HARTKE. That is right.

Miss FEYEN. Services and treatment and glasses are available to persons having cataracts, glaucoma, or who are almost blind. But the "run-of-the-mill" persons who are having difficulty in reading their Bibles or seeing as well as they used to are just out of luck. Improved vision aids immensely the mental outlook of the aged.

Dental care is virtually unknown and false teeth, are unheard of, causing additional nutritional problems.

I think I have touched on many of the economic problems. As to the "other pressures" which may be present, let me say that as an old song goes, "all the stories are true" and for the most part the stories are still being lived every day. I have nothing but sincere admiration and respect for these beautiful senior citizens who have undergone so much so that all of us may one day be free.

Recommendations

As for recommendations, I would give these:

1. An income sufficient to "live," not merely "exist."
2. Availability of medical care either through small satellite clinics and/or transportation to clinics.
3. Availability of home care, particularly in the areas of: home nursing care, health teaching, sanitation, and nutrition.
4. Availability of adequate, low-priced housing specifically for the aged.
5. Free physician's care under Medicare.
6. More "soul" in the Federal program and less "redtape."

Thank you.

Senator Hartke. Thank you for a very fine statement.

STATEMENT OF CONNIE R. MOORE, CENTER DIRECTOR, STAR, INC., MERIDIAN, MISS.

Mr. Moore. Senator Hartke, my name is Connie R. Moore from Meridian, Miss. I am located in the central eastern part of Mississippi, approximately 15 miles from the Alabama line.

I have been with Star since October 1965, and for the first part of the program I served as the field representative for Star. I went to all parts of the State to get the program going, but in as much as most of the complaints and grievances that we have in Star have been covered, I should like to relate one or two instances for your information. These are problems that are not only peculiar to the poor in Mississippi; I am sure they are peculiar to the poor people everywhere.

Loss of Land

The loss of land. This is an acute problem for the poor people in eastern Mississippi. We have small farms and some of our people own a few acres of land. Each year in September we have the sale of land for taxes and so often our people do not have the money to pay the taxes.

You know, according to the law, after 3 years of not paying taxes, the land can be taken. And I have one recommendation along that line at the end of my statement.

The second complaint we have in Mississippi and eastern Mississippi has to do with hospital care. I will relate one instance to you. We had a black citizen above the age of 65 who was in the hospital. He could not get out of the hospital because he couldn't pay for the blood. The welfare agent couldn't get him out because the welfare department wouldn't pay for the blood. So the agent came to our office, Star, Inc., and asked me and the counselor to go and get the man out. We went out to the hospital to get the man out. We were abused and called indecent names, but we persisted and got the man out of the hospital.

These are some of the problems that we don't realize the poor face.

Another problem that they have here in the State of Mississippi, and throughout the country, has to do with the information on services that are available. For instance, a lady 67 years old came to our office some months ago for food stamps. She said her house was leaking and

that she had no money to repair the roof. She was on welfare. The welfare lady did not tell her that they had money available to fix the houses, but after going in and talking to the agent, they decided that maybe they should go out and fix the house. Had I not gone with her, they would not have told her about the fact that they had money available.

Information Centers

Now, these are some of the things that Star achieves in Meridian, and through the State, which helps these situations.

First, we have information centers. We have gone from church to church in the poor parts of the city with our counselors, recruiters, our assistants and our job specialists and thereby bring the people in and tell them to disseminate to them information they should know.

We have also at our center a quilting club where old ladies can get together to quilt and socialize and talk and just be human beings. Otherwise, they are at home, and man, being a gregarious animal, suffers from loneliness.

In the county, we have developed a development club, and this is a good thing where the poor can learn to organize. Development clubs can be assisted by the county, and Star has done that, particularly in Lauderdale County.

These are some recommendations, in light of the previous request for recommendations. I think that in the line of learning the poor need some assistance, and they need some protection. Now, in the case of mental incompetence, you shouldn't be able to take the poor's land. There should be some law on the books whereby a person who owns some parcel of land should not be forced to lose that land. I don't know whether it would be a State law or national law, but it deserves our attention.

Another point has to do with nursing homes. We need to bring the price and the fees within reason. Here in Greenwood I noticed that the cheapest price is $375 a month. The other one is $550. These are exorbitant prices blacks nor poor whites cannot afford.

What should be done in respect to your committee supporting legislation is to improve existing services that are being supported by OEO and the Department of Health, Education, and Welfare and other agencies.

Thank you.

STATEMENT OF ALIX SANDERS, REPRESENTATIVE, MISSISSIPPI RURAL LEGAL SERVICES

Mr. Sanders. I would like to make a correction. I am not the director of the Mississippi Rural Legal Services, and he suggested to me I would be appointed since I am a native of Greenwood and was instrumental in getting the services opearting in Greenwood. He said he didn't think he would be able to come, and he hoped I would be able to provide the information you are seeking.

The problem, I think, has been adequately defined, and I will confine my remarks to explaining, as briefly as I can, the problems and what we are doing here.

The Mississippi Rural Legal Services is an OEO-funded program

and presently operating in five towns in northern Mississippi. Those towns are Oxford, Batesville, Holly Springs, West Point, and Greenwood. The West Point and the Greenwood offices were opened recently.

The program tries to operate in two areas, that is, to relieve the immediately need of the particular client, and after a period of time to seek out those areas by which we may find a means of effecting some reform.

I was assigned to the program as a regional Herbert Smith fellow with the idea that we would bring law reform. I am a native of Mississippi and of Greenwood. I find I am functioning more as a staff attorney in the program doing no law reform.

However, by dealing with clients every day with immediate problems, we find that we are more able to isolate the problems and the areas that would lend themselves to Federal litigation, appellant litigation, than we would be had we merely sat in an office and waited for somebody to say, "Well, here is law reform. Go to it."

Our clients come in primarily after the problem has existed for a long time—after there is a foreclosure sale on land, after they have been cut off of welfare, after going time and time again to social security offices and told they are not eligible for social security. They come in and they say, "can you get me my social security? Can you help me with my welfare?" So we are finding much of what we are doing is social rather than legal.

Having recognized that, the program instituted a social aspect of the program, hiring professional social workers and hiring within communities community workers. These individuals function in three of the towns to talk with elderly people or young people, for that matter, to know what their problems are, to help them come into the office when they need to come in. Quite frequently they will have to set up appointments, send out a person to pick them up, bring them in, file the papers, and send them home.

In the offices where we are, we are not so fortunate. We find we spend much of our time as lawyers in the back of the car, wherever we can hustle a ride, to help the client come in.

Land laws in Mississippi are terrible. They are all for the landlord and none for the tenant.

We find other problems growing out of the fact that we are fighting a political battle. The program quite frequently can measure its success by the amount of political opposition it raises.

I heard earlier that there is only one legal service program in Mississippi. That is not true. There are three, and perhaps four with the new program. But that is true because it is my personal opinion that the north Mississippi Rural Legal Service program is doing the job. The people know about it before they come in, as opposed to a couple of other programs which seem to be functionaries of the local political power structure.

Thank you.

STATEMENT OF KENNETH DEAN, CHAIRMAN, MISSISSIPPI COUNCIL OF HUMAN RELATIONS

Mr. DEAN. Senator Hartke, staff members and distinguished guests, it is indeed a pleasure to have the opportunity to testify at today's hearing. We of the council on human relations are particularly glad

that this committee has seen fit to come to Mississippi to learn firsthand the problems of the elderly living in rural America.

Unfortunately, more and more high-ranking officials in the executive branch of our Government are telling agencies such as the Mississippi Council on Human Relations to quit turning to the national level for assistance with their problems, but to go directly to the State governments.

Beyond the problem of trust and the question of sensitivity, our State does not have the resources to deal with many of the problems. Your presence in Greenwood is timely and serves as encouragement for many of us who work with the poor, elderly, and various minority groups.

I would like to submit, as a part of my testimony, a booklet.

Senator HARTKE. It will be a good reference.

(The booklet "The Will to Survive" by Anthony Dunbar, is retained in committee files.)

Mr. DEAN. This booklet was found by the Council on Human Relations to depict the problems. It is a piece of work entitled, "The Will To Survive," by Anthony Dunbar, with an introduction by Senator Charles Percy.

This booklet is a social analysis of a rural Mississippi community. While the subject of the report is not limited to the problems of the elderly people, I think it well describes the context in which our more serious problems of the elderly develop.

This report is based on the actual words of rural Mississippians, many of them elderly.

With the submission of this booklet, which does have to do primarily with black people and after making reference to a report which I did earlier for Senator Joseph Clark's Committee on Manpower and Poverty, I hope to move on and talk about a problem of elderly people which has nothing to do with race. The reference to the report which was made to Senator Clark is that the Council on Human Relations found three very serious causes of poverty in the State of Mississippi and probably the second most acute has to do with problems of the elderly.

I am going to move on and talk about a subject that has not to do with race at all. This does not mean that we at the Council are unconcerned with the problem of discrimination or problems of black people who suffer injustices. But because there are other problems of the elderly which we might overlook that are very serious in Mississippi, and in the entire southern region in general, I want to move beyond race.

POOR AFTER PRODUCTIVE LIVES

The problem which I want to speak about has to do with the growing number of elderly people who have lived their lives as members of either the lower middle class or low-income working people—and even the middle class—who find themselves in the old-age category without economic security. I am talking about persons who have lived productive lives, who have worked hard to pay their debts, who have established good credit, who have not been numbered among the poor, who have reared families and now in old age find themselves dependent on their children for financial assistance so that they might maintain a decent standard of living.

Oftentimes these persons will be receiving social security and/or some other form of retirement benefit, but in their old age their earning power and their incomes have decreased considerably.

While this decrease is taking place in their income, the necessities of life have continued. The price of food, medicine, housing, clothing, transportation, and other financial obligations remain as necessities, and in almost all cases, the costs have gone up.

Unfortunately, all too often the response of America in such cases is found in the old adage that "charity begins at home." It has been my experience that when these people become dependent upon their children, this usually results in numerous problems in family relations, in personal self-image, and in any emotional satisfaction at all insofar as life is concerned for the elderly.

I don't have any statistics or study to present to you, but almost daily as a Baptist minister, as well as one concerned with the Council on Human Relations, I receive reports from both black and white elderly people who find themselves in this kind of predicament. The emphasis that I want to specify is not that I am displeased with the fact that children have to support elderly parents, but the fact of the matter is that it is demeaning, degrading, demoralizing, and causes a loss of hope for elderly people who have worked hard all of their lives to find themselves financially insecure and unable to enjoy the later years of their lives.

I think with the increasing lifespan and more people living to reach an old age, this problem is rapidly becoming a very serious problem, and I would hope that some attention could be given to this as we consider the elderly of America.

Senator HARTKE. I don't think that a 66-year-old daughter of an 88-year-old mother should support her mother.

Mr. DEAN. Not only that, but I think that when you have very poor people who have never known a meaningful standard of living, while this is tragic, I think it is also just as tragic for a man who might have been a railroad engineer all of his life to become poor as he enters retirement. I know such a man who became ill 18 months after retirement. He owned his home. He owned his car. He had $4,000 in the bank. But through an illness, he lost his home, he lost his car, and he lost his $4,000. In the second phase of his illness, he lost his insurance. This man came to me because he had to go to the hospital. He didn't know how he was going to pay the $50 for admittance to the hospital. This is tragic. Now, this is not a man who has been discriminated against, but this is a hardworking American, who because of his age and position, finds himself increasingly financially insecure.

Senator HARTKE. It seems that some people never find themselves poor until they get old.

Mr. DEAN. Right.

Senator HARTKE. Thank you for your fine testimony.

STATEMENT OF JAMES E. WILLIAMS, DIRECTOR, PROJECT FIND, WINONA, MISS., ACCOMPANIED BY TAL FOWLER, REGIONAL REPRESENTATIVE, NATIONAL COUNCIL ON THE AGING

Mr. WILLIAMS. Senator Hartke, ladies and gentlemen, at this late hour whatever we say will have to be said in valedictory to the fine statements that all of my fine colleagues have made.

We come to you today representing Project FIND, a community action program designed to locate and to serve the elderly who are friendless, isolated, needy, and disabled.

It is no longer considered a new program; however, it is a unique program. There are only 22 such programs in the United States. Twenty of these projects are located in the cities or metropolitan areas with only two in the rural areas—one in Missouri and ours in Mississippi.

In our six-county area, consisting of Attala, Carroll, Choctaw, Holmes, Montgomery, and Webster, there are 12,000 elderly people that are 65 years old and older. Eighty percent of these elderly poor people may be classified as chronically poor.

We might be in a position to give you a background of this information. In Attala County there are 1,900 whites, 590 Negroes, for a total of 2,580 elderly citizens.

In Carroll County, there are 860 whites, 570 Negroes, for a total of 1,430 elderly citizens.

In Choctaw County, there are 940 whites, 150 Negroes, for a total of 1,090 elderly citizens.

In Holmes County, there are 1,100 whites, 2,290 Negroes, for a total of 3,390 elderly citizens. This is the sleeping giant as far as the colored race is concerned.

In Montgomery County, there are 1,350 whites, 490 Negroes, for a total of 1,840.

In Webster County, there are 1,360 whites, 250 Negroes, for a total of 1,610.

The words we say to you today in valedictory will be around a target area of 12,000 people.

Project FIND—Its Purpose

The purpose of Project FIND is to continue to administer a program designed to seek out the unsolved problems and unmet needs and work out ways and means whereby the elderly poor individual's needs may be met.

Project FIND, as you already know, is a three-way program:

1. It is a research project to find new facts and information to assist the elderly in reaching a longer and better life.

2. It is a demonstration project designed to show or explain with examples or instances the existing circumstances found and the solutions needed to deal with the particular problems.

3. It is a service project with social service aides making their daily contribution to the welfare of others.

During the time that the present program has been operating, the entire staff, ranging from the director and his administrative staff down to the social service aides, have spared no pains in giving unlimited time, effort and service to the fulfillment of the program aims, which are:

(1) To locate the elderly poor living in the community.
(2) To identify their needs.
(3) To recognize their problems.
(4) To determine their resources.
(5) To refer individuals to existing agencies, such as: the health department, the welfare department, employment agencies,

Social Security Administration, housing agencies, legal assistance agencies, and the other agencies. When we say "other agencies," we include such agencies as social action agencies, the churches, and the other societies and clubs.

In order to get facts about the living conditions of the elderly poor, aides prepare questionnaires and case worksheets in an effort to reach the individual's primary problems.

Project FIND's budget for the year 1969 represents $60,000, to extend services that would appear to represent resources far beyond perhaps double the allocated budget. Therefore, it has been necessary that each aide help stretch this amount by developing services which we call self-help projects.

Self-help might best be called volunteer services for it may mean asking friends and communities to give their assistance. This supplement and support to our program has added strength to the services rendered by Project FIND aides.

Adjustments and a great cutback in the budget limited our source of supply to the elderly. However, operation has continued. Research and referrals have constantly verified the tremendous task ahead for social work with the elderly.

The people responsible for projecting and administering the program have grown and developed into one of the CMI's most capable, coordinated, and highly motivated staffs.

Under the directorship of Mr. James Williams, of Kosciusko, and the newly elected social service director, Rev. Claudell Miller, of Kilmichael, and the 59 social service aides in the six-county area, Project FIND has received many requests through telephone calls, personal visits, and other contacts that Project FIND is one of the most needed programs in this target area. It is a must.

Out of the Mainstream

Canvasses made by our aides documenting the needs of these senior citizens is proof that the services rendered are essential. These elderly residents failed to stay in the mainstream due to lack of education, membership in groups in which society discriminates, apathy and a sense of hopelessness, lack of provisions being made for retirement and old age, lack of acceptance of society for golden age or elderly people.

Many of the Project FIND clients are found to be living alone with no one to tend to them, care for them, or help them in any way. That is why the jobs performed by the social service aides are important to help these older citizens live a longer and better life. Some of them refer to these social service aides as coming and helping them to have a more abundant life.

A reflection of the survey in research and demonstration of Project FIND aides and staff shows the need for an expanded program has become more important. Efforts have been less successful than desired to completely fulfill services to entire groups of elderly poor residents of the six-county area. Therefore, expansion must be improved and extended for the benefits of the individuals served.

Progress on a full-scale basis is essentially needed to meet the requirements created by the increased number of elderly citizens. The potential is here surrounded with sorrow and distress. An increase

in the budget would allow salary increases for staff, employment of a nurse, also, handyman, area captains, additional aides, and additional time for social service aides. This would greatly implement our program.

The upgrading of Project FIND through the years ahead appears to present a structure resembling a simple object, a ladder, with the rungs neatly scheduling the year and the place to attain benefits for a longer and better life with the knowledge and assistance for the elderly antipoverty group.

There is no way for us to glamorize our case to you, Senator Hartke, this afternoon. We think that our colleagues have already glamorized our case to you. We want to make a part of our testimony and our effort a full authentic documentation of our Project FIND program in the six counties for the last 18 months. We hope that you will be able to help us to get those things.

Again, I say to you in valedictory that you have seen the people here who were able to come. The group that we represent was not able to come to you today, but they told me to bring to you this message. They told me to tell you they are a proud group. They are not where you expect to find them, on the national highways, you do not see them in the metropolitan areas; but you find them on the roads and the places where people seldom go.

You have heard my colleagues tell you this afternoon that these people out there seem to look back at the woods and forests and say, "Why has America turned us over to the general ravages of time?"

We believe that you are going to do something about these conditions. We believe that you are going to supplement all of these programs. Finally, we believe that untapped resources are available for senior citizens, and that the problems do exist and will not diminish by ignoring them.

However, by integrating aging problems into community action and with cooperation and coordination from all agencies and organizations, we shall overcome the various attitudes and traditional practices which exist and provide a gateway, a reentry into society for the older American. I thank you.

(Additional information appears in app. 1, p. 391.)

STATEMENT OF TAL FOWLER, REGIONAL REPRESENTATIVE, NATIONAL COUNCIL ON THE AGING

Mr. Fowler. I have three recommendations, and this will be the limit of my testimony.

I recommend a guaranteed annual income for the aging. This income should be above the poverty level. There should also be built-in adjustments to the standard of living. I believe that we must begin to think in terms of incomes that will bring people out of poverty rather than perpetuating poverty.

The second recommendation is for a Federal low-rent housing program for the aging in rural areas. I feel that there are many of them who want to remain in the environment where they grew up, and they have a right to decent housing in this environment.

Connected with this, I recommend a federally financed home maintenance and repair program for the aging. There are many of the

aging who do own their own homes, and they would like to continue owning them, but they are caving in on them. They are liabilities to their health, to their welfare and to their financial resources. With a federally financed home maintenance and repair program, many of them could continue living in the homes where they desire to live, and with this finance through a governmental resource, they could maintain their homes, without them being a liability.

These are my recommendations.

Senator HARTKE. Thank you. I appreciate them, and I think they are all very good.

Mr. WILLIAMS. These are further recommendations in our conclusive summary.

From the contacts made and the various studies conducted, we have come to the conclusion that the following services are badly needed by the elderly poor in our target area, in order to provide service to the elderly poor who remain in their own homes.

First is what we call supportive services. We think that transportation should be provided for these services, for both the clients and those working with the clients.

More mobile health units; friendly visitation programs; social service programs; food stamp programs; home health programs; home repair programs.

Second is supportive service programs. We heard that mentioned too, and this is a service that helps the elderly poor comply with programs for the elderly poor. So many elderly people don't understand the programs, and there are people who are anxious for them to understand. A program to explain the local resources and services, based on the local needs of the elderly poor.

Third, health maintenance: theraputic and diagnostic services; nutrition and meals; appliances, dentures, hearing aids; accident prevention; protective services.

And as the problems arise, further medicare alerts.

Senator HARTKE. Thank you.

Our concluding statement will be by Rev. Nathaniel Macheski of St. Francis Roman Catholic Church.

STATEMENT OF REV. NATHANIEL MACHESKI, ST. FRANCIS ROMAN CATHOLIC CHURCH

Reverend MACHESKI. Senator Hartke, concerned citizens, in the name of all of us, we would like to thank you for coming to Greenwood. We feel this afternoon a case was established for action, immediate and meaningful for the aged.

THE HUMAN DIMENSION

We make a special plea that you approach these problems with heart, aside from the statistics of the situation, and we hope that somehow you will carry the voice of all of the ages in our county, and in Mississippi. Carry this voice back to your full committee and stress the great need for heart in approaching these problems because there is one very important dimension that needs to be stressed and that is the human dimension.

I think the case is certainly established from all of the excellent testimony you heard this afternoon, but never discount the importance of the human dimension.

Something mysterious, almost magical, happens to a person in need when they know that somebody cares. They may not be able to do a great deal for them, but just knowing that somebody cares makes a big, big difference.

For far too long aged people in our community have known—not felt—that few, if any, cared about them. Can any of you here this afternoon know what it means to have lived a life of backbreaking labor in the cotton fields or cotton warehouses and then to be told in the twilight of one's life that "if you were not so lazy, you would have saved for your old age?" Or to be told, "If you had been a better parent, you would have trained your children to look after you?"

Senator, I have looked into tear-filled eyes of old people who heard such things from social and welfare workers who used such a cruel way of reminding old people that they were a burden to society, and somehow if they happened to be black, they were somehow less than a person.

I have heard old people say that they lived in the hope of one more Christmas just because the little party for old folks here at the center was the biggest day of their lives because it proved that somebody cares.

Senator, please carry, indeed, to every member of your committee the voice of all the aging members of our community. They can point to a life of loyalty to the American system, they can show you a record of loyalty to the American system, they can show you a record of many years of hard work, they can tell you in a voice mellow with age, enriched with sincerity, that they have survived by their faith in America and their confidence in the American dream. But before their life's candle flickers out, they hope—oh, how they hope—that America will show it truly cares.

America should show that it cares quickly and meaningfully by using the resources these aged persons have helped develop, by using it now to make every minute of their waning lives rich and content so that their loyalty, their faith and their hope will not have been in vain.

Thank you, Senator.

Senator HARTKE. I want to thank you for a very moving and inspirational statement, and for what I think has been a very good afternoon for us on the Committee on Aging.

I might point out to you that we are counting on some people here—we are counting on the press, and we are counting on them very much. The truth has not always been heard in this country, but it must be heard in these troubled times.

We are living in an age of anxiety and great frustration in which many people are not sharing in the affluent life of the great and most powerful Nation of the world, a world which—and as you have indicated—has not put enough emphasis on caring and not enough emphasis on that part of life which is not material.

We have talked mostly about economics this afternoon, but only the economics of necessity. We are not really talking about what that

widow has or whether you are dealing with abundance. These people are not living in abundance.

I might say I wonder whether we have gone too far already, and I wonder whether you are going to find an answer.

I think you can take a look around. As I have indicated, we are willing to spend $1 billion for an SST. Just look at the priorities we have in America—$1 billion for an SST, and we are going to spend $25 billion for an antiballistic missile to save us from some threat of a missile coming from a foreign country and $80 million a day for a war in Vietnam, which is almost a million dollars every 15 minutes. Just figure that out and see what you could do in this country to solve our mammoth domestic problem if we had that money.

This country is not going to be great by using its fists, but it is only going to be great by using its ideals. I hope we can take this country and turn it around, from a country of war to one of peace, and from one of despair to one of hope and from hate to love. If we do that, this problem will be solved and will be solved quickly.

I want to thank you for extending your facilities and your courtesy and your hospitality to us, for it has been a very good day.

Thank you.

(Whereupon, at 4:50 p.m. the committee adjourned.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1: SUBMITTED BY DR. DAVID E. WEEKS, M.D., DEPUTY-CLINICAL DIRECTOR OF TUFTS-DELTA HEALTH CENTER [1]

Senator Hartke, ladies and gentlemen, thank you for the opportunity for me to present some of the issues related to our aging citizens and some recommendations that I believe can be helpful in meeting the needs of the elderly.

Tufts-Delta Health Center is an OEO-sponsored Community Health Center operated under the auspices of the Department of Community Health and Social Planning of Tufts University, School of Medicine. The goals of the health center are to operate:

> * * * a project for the creation of a comprehensive health action program under university auspices to intervene (in both an urban nothern and a rural southern population) in the cycle of extreme poverty, ill health, unemployment, and illiteracy by providing comprehensive health services, based in multi-disciplinary health centers oriented toward maximum feasible participation of each community in meeting its own health needs and in social and economic changes related to health * * * [2]

Tufts-Delta Health Center is located in Mound Bayou, Mississippi in the Delta. There is 14,500 target population in 500 square miles. Our services include a complete out-patient care, environmental health improvement, community organization, nutrition program, family planning, health education, and economic development.

I am including some reprints of reports that give a more complete description of Tufts-Delta Health Center and its activities. They are:

1. The Health Implications of Tufts-Delta Health Center, presented at Dean's Day, by David E. Weeks, M.D., M.P.H., Tufts University School of Medicine.
2. Tufts-Delta Administers Environmental Treatment, by Andrew B. James, R.S., M.S., Journal of Environmental Health, March–April, 1969.
3. A Stir of Hope in Mound Bayou, by Richard Hall, Life Magazine, March 28, 1969.
4. Health Center in Mississippi, by H. Jack Geiger, M.D., Hospital Practice, Volume 4, Number 2, February, 1969, Pp. 68–81.
5. Health Care in the Mississippi Delta, by Cynthia Kelly, American Journal of Nursing, Vol. 69, No. 4, April, 1969.

It is widely recognized that the elderly are at greater risk of acquiring a serious, chronic debilitating, life threatening disease than are the youth or the middle-aged person. The relationship between disease and poverty is well recognized and there is no need to comment on it further. It has also been well documented that the life expectancy for all age groups is shorter for the black person than the white. Other data support that the black elderly have the poorest health of any single group in our nation. For example, the black person in the South has the lowest average hematocrit of any group in the U.S.A., and this is especially true for the elderly (National Center for Health Statistics, Series 11, No. 24).

---

[1] See statement, p. 349.

[2] Tufts Comprehensive Community Health Action Program, Department of Preventive Medicine, Boston, Massachusetts, June 11, 1965, p. 3.

The fact that a person is elderly, black, poor and lives in the South means that person is at the greatest risk of having ill health, debilitating disease, and of dying.

This fact is further compounded by the lack of health service for this same population. The lack of health services has multiple determinants. These determinants include lack of facilities, lack of sufficient number of physicians, nurses, lab technicians, x-ray technicians, social workers, and health educators. This quantitative lack is intensified by racism and lack of concern by the health profession.

Therefore, it was of little surprise to us at Tufts-Delta Health Center when we started to provide comprehensive health services to 14,000 black people in rural Mississippi that the 11 per cent of the 14,000 who were over 65 constituted almost 20 per cent of our clinic visits and that almost 50 per cent of our home visiting nurse efforts were directed to the elderly. Neither was it surprising that a vast amount of neglected disease was found in these elderly patients.

For example, an elderly bedridden man who had not been able to receive care was brought to our clinic weighing 327 pounds. The man was found to have massive accumulation of fluid in his body. He was placed on a diuretic and in three weeks his weight dropped from 327 pounds to 192 pounds. The 135 pound weight loss was all due to loss of the accumulation of fluid.

Another elderly patient came to the clinic with a history of several years of gradual loss of vision and pain in both eyes. She had not obtained adequate care before because of the cost. She was found to have glaucoma, and is now blind. This patient's vision could easily have been saved if medical care would have been made available to her a few short years ago. She now lives by herself in a remote shack, living on welfare payment.

We are providing care to a 67 year old, partially blind woman who is unfortunate enough to own 40 acres of land. Though partially blind, and in ill health, she is trying to eke out a living with the 40 acres in cotton. Because she owns the 40 acres, she is not eligible for welfare payments. Because she is partially blind, ill, and elderly, she cannot manage the 40 acres. Taxes have not been paid on the land, and she is in debt. It is just a matter of time before the land will be taken from her.

A 74 year old man was recently seen in our clinic with an obstruction of the urinary bladder. His bladder was enormously enlarged, and he was in severe pain. He had been in this condition for several weeks. He lives alone in a shack in the middle of a cotton field with the cotton up to his front door. He receives $60 a month welfare payments. With this, he pays rent and tries to buy sufficient food. Because he receives only $60 per month and must pay rent, he cannot afford food stamps. He was admitted to the hospital and on discharge this man will face almost insurmountable problems of existence.

These examples are not the exception but all to often the rule and can be duplicated repeatedly not only in our target area, but throughout the rural south. The problem of neglected disease in an elderly, poor population scattered over a rural area with inadequate transportation and inadequate services, even if transportation is available, is not readily solved.

Immediate action that could be taken could include:

1. Funding now for the development of community based and community operated Day Care Centers. Such centers could provide at least one adequate meal a day, a place to socialize, and a place where supporting health services could be provided.
2. Funding could be immediately made available to broaden the support for the poor on entering extended care facilities.
3. The State of Mississippi could broaden its Medicaid Program beyond those persons who are on welfare.
4. Funds could be provided for a pilot transportation system in a poor rural area. Only by providing the transportation, can the rural poor ever have access to health services, as well as the other life sustaining services which they require.

Longer term action would include the Federal Government increasing and intensifying its efforts at identifying, recruiting and assisting the black, rural youth into entering health and related professions.

Furthermore, the Federal Government must, through a variety of agencies, make every effort to provide health services to rural Mississippi.

EXHIBIT A. THE HEALTH IMPLICATIONS OF TUFTS-DELTA HEALTH CENTER

What are the health implication of Tufts-Delta Health Center? This could be answered in a variety of ways depending on the perspective taken. I will try to present just a few answers from some of the varied perspectives possible.

First, what are the health implications of Tufts-Delta Health Center for the individual recipient of the medical services provided? Simply stated—for the first time some 14,000 socially, economically, educationally, and medically denied and deprived individuals, living in the most affluent nation in the history of man are finally being provided comprehensive health services.

For the first time, the people living in the 500-square mile target area in the Delta have available and accessible health services that the majority of Americans have never had to do without. The health implications are: there will be fewer malformed infants born, fewer infants will die, fewer children will be stunted in their physical and emotional development, fewer adults will be disabled, and fewer of the elderly will spend their last years confined to a shack in a sagging bed that is saturated with bodily excrement.

There will be less neglect of chronic disease.

There will be fewer families living in shacks. There will be more adequately fed families, and more families will have potable water supplies in their home.

There will be less preventable disease occuring.

There will be less mental anguish and less humiliation when seeking and obtaining services.

Accompanying these changes of fewer deaths, less disease, less disability, less discomfort and less dissatisfaction will be rising expectations and increasing demands in a population that has expected and demanded so little.

What are some of the implications of Tufts-Delta Health Center from the perspective of the University? I suspect there could be as many different answers to this as there are faculty and alumni. My intention is to present the implications as I see them, in reference to research and medical education.

The existence of Tufts-Delta Health Center implies the recognition by the University that our traditional health services, especially for the poor, have been inadequate. There is not only a gap, but a wide canyon between the fantastic gains in medical technology and the application of this technology to those who need it. This gap is not new but society is now finding this gap unacceptable and is demanding that efforts be made to close it.

On one side this canyon wall has been our traditional services, i.e., the hospital, outpatient department, and private physician and on the other side of the canyon is a large population needing and demanding health services.

Closure or narrowing of this gap requires more than just increased expenditures of dollars, or more physicians, or more hospitals, or more clinics. How much more of these is society going to provide the health profession? Already our health care services in this country cost over 50 billion dollars a year. A society facing rising demands on one hand and competition for scarce resources on the other—will not long permit us the luxury of expending these sums without asking if there isn't a better way of doing the job.

If it is not more dollars or more facilities or more physicians, what will close the gap? I think the answer is knowledge. It is the knowledge of how to create new institutions and systems of care. It is the knowledge of how to organize and deliver the skills necessary to bring the benefits of our technical progress to a population that needs it.

What has created the gap between health service institutions and the population? Several factors have been identified that include—

- Lack of availability of health services;
- Health services that are inaccessible to the population;
- Sharply fragmented care;
- Uncoordinated and inefficient care; and
- Impersonal and hurried services provided by disinterested personnel.

To overcome some of these barriers the concept of community health services has evolved. These community health services has been placed in the community they serve, they try to provide their services at hours best designed to meet that community's needs.

Family Health Care Groups have evolved from these community health services as a method of providing coordinated service and has helped overcome the problem of fragmented care. However, the Family Health Care Groups have

required new kinds of professional organization and changes in the usual professional roles.

At Tufts-Delta Health Center this has resulted in the physician not only being challenged with the traditional problem of direct patient care, but finds himself thrust into a much broader arena.

He not only must diagnose and treat a disease entity, but becomes involved in trying to seek solutions to the socio economic and environmental factors that are major determinants of the patient health. Though the individual physician may not directly solve the problem, he participates by assisting in the identification and definition of the problem and advises on the adequacy of the solution. To do this he must not only work with the usual nurse-laboratory-X-ray-pharmacy complex, but must collaborate with social service workers, environmentalists, health counselors, and community organizers and leaders.

We don't have the answers or how best to organize these Family Health Care Teams and we are still groping for the best solutions.

It is not easily accomplished because of the inherent conflicts involved. How does the needed unity of service evolve out of the multiple disciplines required to provide that service?

How does one resolve the conflict between the need for organized, coordinated action on one hand, and on the other the traditional independent activities of professional health workers?

We certainly don't know the answers, but the implication is we need and will continue to try to resolve these conflicts. We believe the potential advantages to be the individual patient and community are well worth our efforts.

These Community Health Services located in the community and centered around the Family Health Care Group, however, is still not a sufficient answer to close the gap between technological progress and the population served.

No matter how accessible, available, coordinated and efficient we provide services to an infant with diarrhea, little is accomplished if we simply return that infant to the same home environment from which he came. If his home lacks potable water, has a dirt floor, or lacks a sewage system, we accomplish little with our efficient medical care services.

We accomplish little if the family lacks the resources to even obtain food stamps.

To resolve these issues, requires not only Family Health Care Groups but a Community Health Action program to bring about true social and environmental changes.

Indeed, it is only this collaboration between comprehensive health service and community action that can break the unending—self perpetuating cycle of poverty, malnutrition, disease and dispair.

To do this we need more knowledge, and to acquire this knowledge we need to carry out research. Academic centers should and are beginning to devote the same energy and efforts to this kind of research that they have expended on such things as molecular biology.

To carry out this research in a meaningful way a laboratory is needed. The laboratory must provide the environment where hypothesis can be formulated, relevant measurements made, the variables identified and manipulated, and the validity of the hypothesis tested. To obtain relevant data, it would require the service, serving as laboratory, must be operated in a warm, human and compassionate manner. One of the most important implications of Tufts-Delta Health Center is that it can provide the opportunity and services to carry out this kind of research.

I believe the new systems of health care services that will evolve from this operational research will result in not only changes in the old institutions but the development of new ones. This places a demand on academic centers to prepare students for new and different roles. The existence of Tufts-Delta Health Center implies the University has recognized the need.

No longer can physicians be concerned only with what transpires within the walls of the hospital or his office. The physicians of tomorrow must appreciate, understand and accept that they are not always the sole key to good health services. They will be just one of many, whose efforts must be coordinated and balanced to meet the needs of the individual and the community that they serve.

Tufts-Delta Health Center can and is providing meaningful training for medical students from Tufts, Meharry, Yale, U.C.L.A. and others. Indeed the existence of Tufts-Delta Health Center and Columbia Point Health Center is making Tufts a national leader in this new kind of medical education.

By observing and participating in community improvement activities, environmental control programs, and nurse home visits the student will gain an awareness and knowledge of the interplay between the individual, the family, the environment and society. This awareness and knowledge can be learned from books and journals no better than we learned our diagnostic knowledge by only reading about it. Our bedside teaching will be out in the homes, our ward rounds will be in the community.

A medical student who spends two to three months observing and participating in our activities in the Delta will be better equipped to be the physician of tomorrow. This is one of the major implications of Tufts-Delta Health Center.

I have so far presented some of the implications of Tufts-Delta Health Center in relation to health services, research, and education. These implications are being realized and appreciated now. What are some of the long-term implications? Obviously, these are fuzzy and not well defined, but one implication is beginning to come into sharper focus.

There is a growing recognition that the skills and knowledge needed to develop, operate, evaluate and modify an institution like Tufts-Delta Health Center is not now represented by any single academic discipline. The knowledge and discipline needed cuts through social science, anthropology, psychology, political science, ecology, medicine, public health, demography, and medical care administration. No one of these is able to provide the needed knowledge and skills. Nor is an individual apt to structure such an academic experience.

The answer may be the evolution of a new discipline which will draw from these other areas, synthesize the relevant segments into a meaningful whole and add its own unique knowledge.

With this knowledge and discipline we could begin to realize the true nature of the man-environment relationship and better provide the framework within which to apply this knowledge to the benefit of man and his community.

EXHIBIT B. TUFTS-DELTA ADMINISTERS ENVIRONMENTAL TREATMENT BY ANDREW JAMES, R.S., M.S., DIRECTOR OF ENVIRONMENTAL IMPROVEMENT, TUFTS-DELTA HEALTH CENTER, MOUND BAYOU, MISS.

The Tufts-Delta Health Center, established in an impoverished area of the Mississippi River Delta country, is a unique health project encompassing the idea that treating an impoverished population's physical ills is not sufficient treatment of ill health, but must be accompanied by treatment of their poverty stricken environment.

In 1965, the Department of Preventive Medicine of Tufts University School of Medicine proposed a project of comprehensive health centers to intervene in the cycle of extreme poverty, ill health (mental and physical), unemployment and illiteracy by providing comprehensive health services to specific areas. The Tufts-Delta Health Center is a part of that project. The Director of the Center is a physician; however, environmental health professionals are working hand in hand with medical doctors as a result of realization that good health includes soundness of mind and body and not just absence of disease.

In order to present the magnitude of the problem in a meaningful way, it is necessary to point out a few facts regarding the social, economic and physical environment of our target population.

Basic Paper presented in part at the United States Conference of City Health Officers, French Lick, Ind., Sept. 29, 1968.

Bolivar County, Mississippi is located in the Delta. It has a population of approximately 68,000 people (1960 Census), with approximately 70 per cent of this population being black. The health center's target area has a population of 15,000 people residing in a 500 square mile area, with 90 per cent of the total population being black. Of the total population in Bolivar County, only 20 per cent are in the 20 to 44 age group; approximately 59 per cent are under 20 years of age, while 9 per cent are 65 years and over. Out-migration is caused mostly by the mechanization of the agricultural industry, specifically cotton production.

The higher the proportion of non-white people in an area of Bolivar County, the greater will be the possibility of productive population loss. Areas that experience industrialization tend to hire whites, thereby causing the non-white to migrate. The average family size of white and blacks is a statistical 4.4 persons; the average black family size is 5.0 persons with some black families reaching 17 to 20 persons. Fifty-five per cent of the white population earn over $4,000 per

year, while 95 per cent of the non-white population earn under $900 per year.

The present O.E.O. poverty guidelines designate those rural families of four earning $3,000 per year or less, as poverty stricken.

SITE SELECTION

Intensive statistical and demographic studies of several southern states led to the identification of Bolivar County, Mississippi as the rural agency site.

For political reasons, the northern district of Bolivar County was proposed as the intensive service area. The all Negro town of Mound Bayou was selected as the base for the health center. This decision allowed black and white staff to work and live side by side. The center is now a physical reality in the middle of a former cotton field.

OFFICE OF ENVIRONMENTAL IMPROVEMENT

The Tufts-Delta Health Center has an Office of Environmental Improvement charged with helping the poverty stricken population improve their surroundings and thereby promoting good health in this region.

The environmental component was included because the Project Director and the Director of Community Health Action recognized the critical gap between clinical and preventive medicine, and the close relationship of health to socioeconomic circumstances. If there was to be a closer rapport between good health and the environment, knowledgeable personnel in sanitation had to be obtained. In my opinion, a truly comprehensive health center could not remove an ill individual from a hostile environment, place him in a controlled hospital environment, treat that individual, and return him to that same old environment to become involved in a new disease cycle. Consequently, the Office of Environmental Health has become an integral part of the Tufts-Delta Health Center. Together with Clinical Medicine, Social Work, Community Organization, Economic Development, and Educational Counseling, the Environmental Health Staff hopes to improve the total health of the target population.

STAFF COMPOSITION AND OBJECTIVES

At this writing, and to my knowledge, I am the only qualified sanitarian who is black in the State of Mississippi. At this stage, for political reasons, it was considered better to utilize black sanitarian trainees with a southern background in our program. Most staff members are ex-teachers with a science background.

COMPOSITION

The Environmental Health Staff is one of the larger units at the center and consists of a director, a supervising sanitarian, two staff sanitarians, two sanitarian trainees, a home economist, and an environmental health secretary technician. Three sanitarian assistants experienced in plumbing, carpentry, and heavy equipment round out the staff. The duties of the entire staff are geared toward improving the environment of the individual and the community in which he lives. Environmental Health goals involve:

a. Self-help programs
b. Community education
c. Technical assistance
d. Home management

The basic objectives are to intervene constructively in the environmental disease cycle of the impoverished, to obtain and train men and women interested and eligible to pursue environmental health careers, and to use environmental improvement as a catalyst to bring about social change necessary for long-term health measures.

STAFF TRAINING

Each professional staff member is required to enroll in the National Communicable Disease Center's sanitary science courses. One workday each week is devoted to in-service training. The entire staff is then exposed to theoretical activities encountered in an urban official health agency as well as actual rural health. This includes food establishment and food service inspections, radiological health, air pollution, private sewage disposal, sanitary surveys, etc.

Classroom lectures are always supplemented with film or other audio-visual aids. Usually, the team has a chance to demonstrate its newly gained knowledge in the field as in the installation of a drainage disposal field, or a drainage ditch. The Mississippi State Department of Health has assisted in placing our Sanitarians in local health departments for on-the-job training.

Because of the lack of opportunity for professional training in Mississippi, negroes have not been adequately trained to become registered sanitarians. However, through transitional college programs and scholarships, two Tufts–Delta Health Center staff members will enter a mid-western university in 1969 to study Environmental Health Engineering. If they are successful, they will triple the number of black sanitarians in Mississippi.

ECONOMIC ENVIRONMENTAL DATA

Preliminary Sanitation Survey

The first official act of this department was to initiate a preliminary sanitation survey. Since there were no staff members at this time, the aid of an interested black community leader was enlisted. This person was responsible for direct inroads into the total community, both black and white, since he commanded a certain amount of respect from each group. This move was so successful that I would certainly advise it to any Sanitarian or health worker with a similar purpose.

Southern black people are somewhat cautious in relating their impoverished conditions to outsiders, black or white. It has been their experience that certain elements of the white power structure such as Welfare, Aide to Dependent Children, etc., sometimes use unconfirmed rumors as a source of information about aid recipients. This information was then used to reduce the amount of the person's allotment check, or worse, to discontinue it. Most southern whites are hostile to outsiders, especially black people, who they consider workers of change.

The hostility of whites was often replaced by interest when they discovered that public health was the issue rather than civil rights. The hostility of the blacks lessened when they considered our interest genuine and the public health problem significant. In most cases, consultations with white mayors, city leaders, and representatives of the black community revolved around the same issues as those previously brought to the fore in civil rights issues. The function of this office was to serve as a catalyst to get the two factions to begin discussions. An example of this relationship is the mosquito control program conducted last summer by this department. Physicians noticed that a large number of their patients in a certain community of Northern Bolivar County had infected mosquito bites. This department was able to initiate a mosquito control program in that area because the total community recognized it as a problem, and one in which they could willingly cooperate.

The preliminary survey was designed to point out the more immediate gross problems in the target area and identify emergency areas. Emergency areas were defined as those areas where environmental conditions were severe enough to prevent the resident population from pursuing good health. Sixteen communities within the target areas were visited and evaluated. All had severe environmental problems. Temporary measures to relieve an immediate environmental crisis were initiated on an individual basis. Long range measures involving total community participation were also planned.

The mechanisms of disease transmission in this area were numerous. Water, sewage disposal, living space, housing, solid waste disposal, and lack of food were prime items of concern.

The practice of sanitation, whether by legal, educational, or cultural means, must be effected if man is to survive in his environment. To survive only, however, does not adequately satisfy requirements for good health, since good health is a state of mental as well as physical well being.

Water

Bolivar County has abundant ground water. Unfortunately, most rural poor (70 per cent of population) cannot afford pumping equipment if a well must be developed at 50 feet or more. A well depth exceeding 50 feet will normally require motorized pumps. Furthermore, some people are so poor that they cannot afford a common pitcher pump or pipe needed for development. Consequently,

many poor people who manage to drive a 10 foot to 20 foot pump find themselves dependent upon Mississippi River seep water. The hydraulic water pressure on the sides of the river bank coupled with close proximity to the river, combines to fill their shallow wells with water in periods of high flow. When the Mississippi River is at low flow, their source of water disappears.

These people then turn to other methods of obtaining the water necessary to their survival. Other methods include catching rainwater in open containers, hauling water from other areas, or using surface water. The topography of the Delta does not lend itself to springs and surface water, but to ditches, bayous, or similar reservoirs of water, either stagnant or moving. The health implications are obvious.

Clinical data reports infant diarrhea as widespread and possibly a significant factor in the black infant mortality rate. In 1965, 56 out of every 1000 black children born alive in Mississippi died before the age of one year. The infant mortality rate for Mississippi whites was 23.6 per 1000 live births during this same period. There is no doubt in my mind that drinking water is important in this area in infant diarrhea and other water borne diseases.

In order to document the presence of possible disease organisms, a study of consumable water supplies was initiated by this office. This study was concerned only with water that was destined to be consumed in the home, and involved 60 families in the urban and rural area of Mound Bayou.

People of our target area now have an alternative to obtaining water as outlined above. They can contact the Office of Environmental Improvement at Tufts-Delta Health Center or one of the rural contact centers. This call will result in a sanitarian's visit to the home. The sanitarian will evaluate the water crises and take emergency corrective measures. This will usually include the chemical or physical treatment of the water to make it compatible with good health. If environmental conditions in the home are particularly adverse to good health and chemical or physical treatment of water cannot be achieved, he may direct a sanitarian assistant to prepare and deliver an approved 55 gallon container of chlorinated water until a more permanent source of water can be obtained.

After the immediate water crisis is solved, a basic sanitary survey is compiled. This survey treats all environmental aspects of the home and its inhabitants. Medical, social, psychological, nursing, and educational referrals are made if needed. At that precise moment all the resources of the Tufts-Delta Health Center are focused on this one isolated family, so that the sanitarian's work is expanded into multi-disciplinary intervention. Thus, the sanitarian is not merely a consultant or a technical resource, working in isolation from the health team and the clinicians; on the contrary, he is a key figure in the coordinated team of professionals and sub-professionals, and he often serves as the point of entry that brings physicians, nurses, social workers, or others into the picture.

Permanent measures designed to persuade community officials and pertinent agencies to install or expand water facilities for the benefit of all its citizens have been attempted. A successful story is that of the community of Symonds, Miss. Over 70 percent of the Symonds population had to haul water during the summer months. Fifty percent hauled water at all times. The people of the Symonds community were simply too poor to pay for equipment and materials necessary to develop deeper wells when the fickle Mississippi deprived them of its seep waters. Through the combined efforts of this office and community leaders, the Symonds Community Improvement Association was formed. The objective of this organization was to work collectively to promote the health of the community. The lack of an adequate and safe water supply was considered to be the community's most serious threat to good health. The Symonds community with the guidance of this office, initiated the engineering work-up necessary to apply for a FHA Loan. Their application was accepted and is awaiting disbursement of funds.

SEWAGE

While the need for sewage facilities, both private and public, was considered to be acute, this situation was aggravated further by improperly developed water sources.

The most common method of rural home sewage disposal was the sunshine privy—a privy constructed without a pit, side or rear wall. When these privies were visited during the initial area sanitary survey, they were not assigned

a very high status. Most of these were in a decrepit condition, however, they might have been a blessing in disguise. At least sewage contamination of the shallow wells may have been avoided, because the above ground deposition of human waste added a buffer zone.

Small cesspools with no secondary treatment serve as the next most common method of home sewage disposal, especially in the congested urban areas. The problem of water-borne contamination is reduced in the small cities because water is a municipal commodity and can be sold at a profit. Water meters, however, are not used on a large scale. Therefore, sewers become a service and not a salable commodity such as water because of the inability to determine how much water is used. The existence of sewered white areas and non-sewered black areas in the same community where sewerage systems exist, is widespread. Essentially, the black man is taxed to support an important health service for whites and he is denied it. The lack of these facilities in one part of a community has a negative effect on the health of those living in another part, since epidemics can cross color boundaries. The Office of Environmental Improvement has attempted to prevent sewage contamination of water supplies by:

a. Assisting the local black leaders in presenting their problems to city leaders.

b. Assisting the rural families in obtaining health-related FHA Loans to correct unsanitary conditions, usually assisting in the actual work.

c. Motivating the community to more adequate methods of sewage disposals.

d. Technically assisting municipalities in the design of needed facilities.

HOUSING

Over 60 per cent of the houses in our target area would be condemned as "Unfit For Human Habitation" if they existed in most large cities. However, big city values were shifted down to include stark survival of the inhabitants.

Complete protection from wind and rain cannot be expected from most of the rural plantation houses, but assistance in nailing a board or repairing a roof, may ignite a spark of hope in the hearts of the impoverished.

The problem of housing is further aggravated by the absence of the traditional landlord and tenant relationship of big city ghettos. In many cases black families are living in the dilapidated shacks, rent free, with the permission of the white landowner. The landowner feels no responsibility for the upkeep of houses of former help no longer necessary to his economic gain.

As a matter of procedure, the sanitarian from the Office of Environmental Improvement must get the permission of the homeowner before making needed repairs or supplying materials. Assistants from the Office of Environmental Improvement can then make repairs.

Sometimes, this office cannot do very much considering the great need of the inhabitants. Screening windows and porches to keep out flies and mosquitos produces a tremendous positive reaction. After any reaction, positive or negative, is evoked the opportunity exists for discussion of other environmental problems.

When housing is considered, living space is inevitably discussed as an integral part of it. However, just providing sleeping space takes up much of the staff home economist's time. Seven or eight children in one bed (or a facsimile thereof) is common. Children, mother and father often share the same room. The effect of such an environment is not conducive to good health. The environment affects the individual, and is in turn affected by the individual. For example, many families do nothing about the deteriorating structures in which they reside, not so much because of trifleness as because of hopelessness.

The Office of Environmental Improvement is involved in the repair of spirits as well as structures through family and community participation. The numerous abandoned plantation shacks are used for materials to repair present housing. This not only spares the meager resources of the O.E.I. and the people, but performs a valuable service to the landowner in clearing farm land.

SOLID WASTE DISPOSAL

The disposal of solid waste is as much an environmental problem in the entire State of Mississippi as it is in our target area. The State Board of Health is presently working on long-range corrective programs in this area. Municipal incinerators and sanitary landfills are few in the state and virtually non-existent

in Northern Bolivar County. Municipal open dumps and wayside dumping by individuals is the usual method of solid waste disposal. The population of rats and other vermin that find food and harborages in these dumps defies the imagination.

The open dumps coupled with dilapidated shacks make the rodent problem a particularly severe one. In one instance, the landowner decided to develop land formerly used as an open dump. O.E.I. received three successive reports of rat bites by the same family and the same infant. Obviously, the rodens simply migrated to the nearest area of shelter, food, and water.

O.E.I. is working with the inhabitants on baiting programs and proper food storage as initial control measures. Long range measures include helping local citizens from private refuse collection agencies and helping municipalities develop sanitary landfills. North Bolivar County has many depressed areas of topography and marginal land suitable for sanitary landfills.

All segments of the community have showed interest in solid waste disposal. White farmers have experienced damage to crops by rodents, while the blacks suffer more directly.

THE ACQUISITION OF FOOD

In the early stages of the center, the various divisions of Community Health Action (includes Environmental Health) actively tried to promote community interest in self-help programs. It was found that the number one priority was the acquisition of food, clothing and shelter. An unemployed female head of a household of 13 expressed her feelings in the following manner:

> "It is nice to learn about health, but I think maybe if you could find us work so we can get enough to eat, there would be a better chance of us having good health."

In almost every contact, this was the case. Since then, a farm cooperative was developed to help meet the basic nutritional needs of 5,000 economically deprived people through a grant from O.E.O.

The Co-op is totally staffed by local people who receive appropriate technical assistance from qualified individuals brought in by the center. Five hundred families whose income was less than $200 per family member per year were chosen to work on the farm and in a small freezing operation. They were paid $4 in cash and given $6 credit toward the harvested crops. The crops were harvested and sold at extremely low prices to residents who met O.E.O. poverty guidelines, and given to the workers according to their credits. The soil in this region is extremely fertile and resulted in processing of over one million pounds of frozen beans, greens, potatoes and other vegetables during July, August, and September, 1968.

The transformation of community interest to involvement in specific environmental health problems has been fantastic and gratifying.

SUMMARY

The Propect Director of the Tufts-Delta Health Center is a physician. His solicitation of environmental health professionals in an area heretofore considered the domain of physicians may be an epoch in the field of public health.

In this instance, unblinded medical men were astute enough to question why a patient returns with a reinfection of one that was formerly treated. Much of the physician's blindness is attributed to their ignorance of the patient's living environment. This is not so much the physician's fault as it is his dilemma.

The basic organizational units of the health center—the Family Health Care Group (internist, pediatrician, public health nurses, social workers and paraprofessional aides—and the Area Coordinated Team (all of the above plus Sanitarians and Community Organizers)—insures that all health professionals work together in a new relationship that enables each one to see and understand the total health picture—clinical, environmental and social. Plans are now underway for medical students and nursing students, as part of their training, to work together with the sanitarian students and the Environmental Health Staff.

A physician administering treatment in a home environment would probably encounter some medical difficulties. Indeed, his treatment of the poor soul may not be as good as that administered in a clinical environment. But, he could never again think of that patient without recalling the conditions under which that patient lived.

I am not advocating the resurrection of the days of the country doctor. The importance of including the patient's physical environment in any program of treatment, however, is strongly stressed. This holds true for all people but especially so for the poverty striken since they constitute a more susceptible population.

It is not the intention of this article to imply that all of the problems have been solved. Obviously, they have not. We do feel that the inclusion of an environmental unit in a comprehensive health care center is imperative if the unit is to have sufficient impact to initiate change. We believe that the total community should be involved in all programs, white and black, the mayor and the welfare recipient, the planter and the sharecropper. Community health associations have been formed in order to provide a base for intercommunication between the center and the community. However, the act of going into a community and providing needed services is sometimes viewed with hostility: (a) from the local or state government because it exposes the needed services that are *not* being provided; (b) from the white community because it exposes selective recipients for services that *are* provided; (c) from the black community because of previous unfulfilled flirtations with hope.

However, beyond the emotion, guilt, and hostility that we have encountered, there is the objectivity and creativity of the staff at Tufts-Delta Health Center. We are attempting to build a small portion of a new America—one divorced from the social and economic poverty of the past and reaching towards the star that is the promise of a new life for all Americans.

EXHIBIT C.—A STIR OF HOPE IN MOUND BAYOU

(By Richard Hall)

U.S. 61 two-lanes out of Tennessee, running downhill into Mississippi, cutting through a string of dusty towns that are little more than clusters of houses on either side of the road, chitlin-switch hamlets with improbable names like Alligator, Hushpuckena, Merigold. Beyond the highway stretches the Delta—flat-chested and imperturbable, covered by a patchwork quilt of cotton. This six-million-acre plain, which makes up the western edge of the state, runs from the Mississippi-Tennessee border as far south as Vicksburg, and is bounded on the west by the Mississippi River, on the east by the Yazoo and its tributaries. When cotton was king the Delta was his fief, but today most of the black people who once picked the "white gold" sit idly on the broken porches of their crumbling tin-roofed shacks, staring at the giant, brightly painted cotton-picking machines that endlessly crisscross the plantations—sucking up the bolls with steel-and-air-hose fingers, plucking them as expertly as human hands once did.

A hundred miles south of Memphis, Highway 61 enters Mound Bayou, Mississippi—population 1,380, one traffic light, three gas stations, a post office, a single railroad track cutting the town roughly in half, separating its affluent inhabitants from those who are less so. Until little more than a year ago the town slumbered like a black pearl in a setting of bitter rural poverty. Mound Bayou is an all-Negro town. Its citizenry ranges from a few wealthy landholders, whose large tracts of land bring handsome profits after the cotton harvest every fall, to just plain middle-class folk, who either teach school, run small businesses along U.S. 61 or hold decent-paying jobs in nearby Cleveland, the county seat. Old money. Family wealth and power go all the way back to before the turn of this century, when the families of Mound Bayou's aristocracy were granted large real estate holdings by their former master, Joe Davis.

About a half-mile west of U.S. 61, in Mound Bayou, is a low, square building, its cement, aluminum and glass facade rising above a scruffy cotton field and the wooden shacks adjacent to it. This one-story, 24,000-square-foot, superbly equipped structure, built with $800,000 of Office of Economic Opportunity funds and run by the Preventive Medicine Department of Tufts University Medical School of Boston, houses the Tufts-Delta Health Center—headquarters of a poverty program which has been operating in the Delta since November '67. It was only four months ago, however, that the new center opened its doors to the poor population of northern Bolivar County. It represents four and a half years of planning and work by Tufts, OEO and the health center's own 150-man staff of doctors, nurses, social workers and other specialists.

Before Tufts came, the people of Bolivar—especially the black—endured the special agony of having their suffering neglected. Nobody seemed to give a damn

about the 75% unemployment rate, the $900 average annual family income, the high infant mortality or the malnutrition and inadequate housing. While the big money from Washington was being shuttled north into the noisy ghettos, the Delta—for the most part—got no attention at all. It continued to laze beneath the hot Missisippi sun, content to grow its U.S. government-subsidized cotton, swat flies and neglect the 250,000 poor—who were more than qualified to be called that, since they earned far less per year than the $2,300 for a farm family of four set forth under the OEO poverty guidelines of 1968.

John Hatch is a tall, heavyset man of 40, with powerful arms and shoulders; his walnut-brown face is gentle, though often brooding. His modest frame house in Mound Bayou is located on a paved street that parallels the railroad track, not far from the Tufts-Delta Health Center where he has worked as Director of Community Health Action for the past two years.

Hatch rose from the table where his wife and three small children sat finishing their Sunday dinner. He was leaving to attend a 4 o'clock meeting of his regional health council—24 poor people, all black, organized by Hatch himself to communicate the needs of the 12 widely scattered communities in northern Bolivar County.

As a youth, prior to migrating north, Hatch had lived in Arkansas and Mississippi, often working in the fields picking cotton. He became a graduate social worker with a master's degree from Atlanta University, and also spent some time studying law at the University of Kentucky. Later, for six years he worked for a settlement house as a community organizer in Boston's tough South End section, and also lectured occasionally on public health at the Yale Medical School.

Three and a half years ago, Hatch joined Tufts' faculty as an assistant professor of preventive medicine, and in January 1967 he came back to Mississippi to "pay my dues," as he puts it. Assigned to scout possible locations for the proposed health center, he explored 50 other sites before settling on Mound Bayou. Now, as he crossed his backyard, Hatch noticed that a nearby pecan tree had sprinkled the lawn with its brown nuts. He stopped picked one up and cracked the shell open. The meat was still soft and moist, not yet dried out. He dropped the nut into his jacket pocket, walked to his 1966 station wagon and drove off in the direction of the health center, less than a mile away.

The new health center has had two predecessors. The most recent was a prefabricated "intermediate" building, which still stands nearby and is used for additional office space. But the original health center was a five-room church parsonage rented in October 1967 from a local pastor and converted within a month into a makeshift clinic. Each of the first two smaller operations quickly outgrew its physical confines—reflecting the almost explosive rate of the Tufs project's growth as it provides medical treatment, medicine, food and social and environmental services for northern Bolivar's poor—85% of whom are black.

The original clinical team had a nucleus of three doctors who came to Mississippi from the Tufts Medical School—Leon Kruger, Roy E. Brown and Christian Hansen—plus five registered nurses and a social worker, Miss Nadia Goss. The program's administrator, Dr. H. Jack Geiger, who had originated the project was—like John Hatch—already there.

Traditionally, the young black people of the Delta migrate north at the first opportunity. They leave in search of jobs and better living conditions, though they do not often find either. Tufts is also trying to do something to retard this rural-urban exodus, which each year—between June and September—saps close to 80% of the black high school graduates of northern Bolivar County. Of the 58,000 county population only 21% are in the 20–44 age group. So Tufts has also started a work-study program for high school students. Each Saturday and after school they train at the health center under professional supervision, helping out in the lamb, the pharmacy, or as nurses' aides. They are exposed to Negro professionals, many former Southerners who have come back to work and live.

Nothing had succeeded in shaking Mound Bayou loose from its imperturbable ways not even the dramatic civil rights demonstrations of the early 60's. So, of course, in the foll of '67 nobody in town paid much attention to the new activity at the Church of Christ parsonage. What impact could a handful of white people from Boston have on an area as vast as Bolivar County—second largest in the state, 923 square miles—and among the poorest in the nation? Besides Mound Bayou already had a 67-bed all-Negro hospital as good as any in the rural Delta. It had served the townspeople and anybody else who could pay for its services. By comparison it made the tentative Tufts operation look hopelessly ineffective.

But the staff at the parsonage grew. Tufts recruited more doctors, more nurses, social workers, community organizers, a sanitarian, a pharmacist. They came from all improvement workers log several hundred miles every week, traveling in staff cars (or in some cases using their own) over back country roads that are either muddy and rutted with muffler-mangling trenches or—on sunny days—chocked with dust. In many cases they drive 10 or 20 miles between visits. In an average week, nonetheless, they manage to give personal attention to hundreds of needy people.

A team of nine specialists led by Andrew James, 33, works to improve the rural environment. James—tall, boyish-looking—is black, a native of Alabama, and has a master's degree in environmental engineering. Fifteen months ago he left a lucrative pob as a county sanitarian in Ohio to join the newly born Tufts project. He is the only registered black sanitarian in the state of Mississippi.

James and his crew drain foul water out of ditches and bayous—some families were drinking it—and install safe wells. They tear down abandoned shacks and use that material to build sanitary privies and repair dilapidated houses. They clean up garbage dumps, fumigate houses for roaches and bedbugs, kill rats—even remove snakes that have made homes in the shacks.

Describing conditions when he took over, James says: "I couldn't believe it. Sunshine privies! Nothing but a board across something.

"We're a pick-and-shovel brigade right now. What we need bady is a backhoe—it would dig drainage ditches in half the time."

"We see so much that sometimes you feel you haven't touched anything," says Mrs. Julia M. Ray, a black home economist with the environmental group. She came to the project about nine months ago from Kansas City, where she had worked as a municipal court social worker. Mrs. Ray, widowed, presently lives in Mound Bayou with her brother, a member of one of the town's oldest families. Her project assignment is to teach the poor about home management and hygiene. "One shack was so dirty we had to use a hoe to scrape off the kitchen table before we could scrub it.

"We need simple things to give the people—toothbrushes, plastic cups for drinking, brooms, mops, soap. Things to clean with. I just don't have enough to go around."

The man most keenly aware of his staff's frustrations is Dr. H. Jack Geiger. Jack Geiger, white, is now 43 years old. At 16 he lied about his age—upping it to 17—and got a job as a cub reporter on the night shift at the Madison *Capital Times*. During the day he attended the University of Wisconsin, majoring in journalism.

In 1943 he quit college and joined th ewartime merchant marine. After the war, he finished college, now a biology major, at the University of Chicago, working nights for the International News Service. After college he became the I.N.S. science editor.

In 1943 he quit college and joined the wartime merchant marine. After the and began to combine his two major interests: civil rights and medicine.

Today Geiger is a specialist in internal medicine and a professor on the Tufts Medical School faculty. He spends one week a month in Boston, sometimes teaching, more often looking after the affairs of Tufts' other health center there. The remainder of the time he is in Mound Bayou or Washington fighting for more government funds, or in New York looking for private money from places like the Ford Foundation. When he isn't doing any of these things, when his shoulders aren't gull-winged from exhaustion and his lamp-sized eyes aren't half shut from lost sleep, he's working at the Tufts-Delta Health Center or flying off somewhere to recruit more professionals for his staff.

Hunger was the most pressing problem facing Geiger and his crew when they first arrived in the Delta. People were literally starving, yet sitting on some of the richest land in the U.S.

"We found everything one would expect and more," Geiger recalls. "Infections, malignancies, an especially high rate of hypertension in adults and infectious diarrhea in childrene. The hunger was incredible! So John Hatch and I drew up a proposal for a grant under the OEO's Emergency Food and Medical Services Program and submitted it to Washington. Meanwhile, I was able to get $5,000 from a philanthropist in Bethesda, Md. We bought two tractors and rented and borrowed 120 acres from Mound Bayou black farmers, and we had 12 acres more that Tufts had already bought and wasn't using. We found the 800 poorest and hungriest families in our district and helped them organize the North Bolivar

County Farm Cooperative Inc.—not just giving handouts or food stamps, but letting people work for what they needed. Then the government grant came through—$152,000."

The farm co-op—owned and operated by blacks—planted its first seeds in April 1968. By October, just six months later, its members had harvested over a million pounds of vegetables—more than the annual amount hitherto grown in the entire Delta for its own consumption. The co-op workers are paid partly in cash and partly in food.

The man responsible for this successful effort is John Brown. Though Brown, 39, has had no technical training and only finished the fourth grade, he is an unusually intelligent man. Since the co-op's beginning, he has managed the actual planting and harvesting operations. He came to Tufts from a farm foreman's job in another part of the country, where he had worked 10 years for a white man.

Says Brown: "We grow mustard greens, collard greens, okra, onions, lima beans, black crowder peas, Mississippi silvers . . . you name it. We've got 180 acres leased now. But we need money to buy 500 acres of our own; an' I need a bigger tractor, too—for tillin' an' plantin' an plowin'. Man, then we could really feed *all* the hungry people around here."

John Brown likes to brag that he planted the first seed with his own hands. Standing in a 20-acre field of co-op vegetables, he kicked at a clump of moist black earth and explained what the Tufts program has come to mean to him: "When Mr. Hatch first tried to get me to come here an' work for the black man's welfare, I had a terrible time makin' up my mind. It worried me sick. I was doin' pretty good. Not makin' much salary, mind you, but enough to feed my wife an' nine children. I was runnin' a 446-acre farm an I had 18 people under me. When I finally decided to leave, the boss man came to me an said: 'John, what have *I* done to you? Haven't I treated you good?' But nothin' he could say could talk me into stayin'. I had made up my mind an I left him. Workin' here for this co-op has just brought daylight into my life." He paused and looked out across the field. "Man, I didn't know before how high my mountain was to climb."

Something else came into his mind and he chuckled. "Just recently that boss man came to see me again an' said: John, I'm gon' build you a new house if you'll come back.' ' 'Well,' I told him 'you go 'head an' build it—somebody else there'll need it.' " John Brown was laughing now.

In less than a year, the co-op has provided hundreds of jobs for the people of northern Bolivar. It has helped feed over 4,500 mal-nourished persons. Last fall the co-op leased a food locker in Cleveland. There they froze and stored hundreds of tons of vegetables, which they have been distributing to the hungry throughout this winter. They are trying to raise $400,000 to open a cannery. The idea is to grow and can "soul food" and ship it north. If the scheme works, it will represent an entirely new industry in the Delta—and provide hundreds of additional jobs for the people of Bolivar.

The meetings of the regional health council, organized by John Hatch, are held every second Sunday at the health center. Here the council members, representing every area of northern Bolivar, present problems which their communities wish to emphasize: an inadequate community water supply, the particular hardships of the sick and old, the need for expert guidance for the young—and, of course, always, the problem of hunger. Hatch's objective at these meetings is to stir those present to strong participation.

Each has journeyed a long distance to get to the health center, riding in groups in prearranged car pools. Now they gather in the white-walled conference room, the fluorescent lights above them over the country, some even telephoning long-distance to say they had heard of the project, that they were black themselves, originally from the South, and anxious to come back and help.

What was going on, the townspeople wanted to know? Why was peaceful Mound Bayou in the midst of all this furor?

But the rural poor already knew what was happening and why. Mound Bayou had been chosen by Tufts because it was all-Negro, as it had been from the day it was founded in 1887 by Isaiah T. Montgomery. Since it was an all-black community, it was insulated against potential harassment by Mississippi whites.

So the word went out among the poor in the surrounding countryside: *Help at last.* It spread quickly as the people carried it up one dusty road and down another, scurrying with it like silverfish in and out of the miserable little shacks—those airless, urine-splashed coffins where the rural poor endure. *Help at last.*

They flocked to the tiny parsonage to receive much-needed medical attention. They sat on the stiff-backed chairs in the crowded living room that had been converted to a waiting room. Some would be face to face with a doctor for the first time. They sat mutely, staring into empty space until their names were called—either by the young white nurse, who looked too young even to have finished high school, or by the black nurse, whose eyes particularly they scrutinized for a hint of *hinktiness*—superciliousness.

In time each was led courteously into one of the three bedrooms that had been converted into treatment rooms. There a doctor spoke gently to them and placed his hands on them when he looked into their mouths or listened to their hearts. But those hearts beat faster when the doctor was white, because it was all so strange, this touching of white hands on black bodies—here in the Mississippi Delta.

"I guess we were practicing missionary medicine back then," says Dr. Geiger. "But at least we were creating a comprehensive health program where virtually none existed. Our aim was to use health as a basis, a point of entry into the poverty cycle, that would eventually lead to broader social change."

Late in the spring of 1968, after six months in the cramped parsonage, Tufts moved into the air-conditioned, 15-room intermediate clinic, on the same tract where the present center is located. Tufts purchased the land from a Negro farmer, using part of a $2.5 million OEO grant made in 1966. In the pre-fab building and outside it, the staff worked and grew while waiting for the present center to be completed.

Hatch parked his station wagon in the new health center's parking lot. A few other cars were there: older models—vintage Fords, Plymouths and Dodges—dust-covered and dented, with bald tires and bodies that seemed to collapse over their frames like exhausted milers. Hatch sighed and slid lower behind the steering wheel, concentrating.

He looked over at the shiny new health center and remembered the original clinic at the Church of Christ parsonage. He recalled the earliest meetings, the agonizingly slow progress for the first six months or so at organizing those who attended; the doubt-filled silences that had followed his first painstaking explanations of why Tufts University had sent a team into the Delta, and how its ultimate aim was to help people to help themselves.

John Hatch was black, but in the minds of his listeners a huge gap had existed. He was a college-educated Negro who had given up a big job in Boston to come down to the Delta. That fact alone was sufficient to cast doubt on his sanity. But Hatch had borne it all with characteristic patience. His father had been a preacher; and the memory of strong sermons burned in the son's brain.

So he waited the people out: endured their silence, their suspicions, their awe of his education. He went on working, telling them what the future could hold if they banded together. And now they trusted him, confided in him, depended on him.

Yes, it would be a fine meeting, he decided; the people were ready. He glanced at his watch, got out of the station wagon and confidently climbed the steps of the new center.

From its feeble beginning in 1967, the Tufts staff swelled to its present complement of 10 doctors, 10 nurses, two trained midwives, plus 23 other professionals—including social workers, clinical technicians, a psychologist, a nutritionist and a pharmacist. Twenty-nine of its professional staff are black. To date, the Tufts doctors, nurses, social workers and environmental teams have treated without charge more than 8,000 people—black and white. Its nursing staff alone has made more than 10,000 home visits, mostly to the bitterly poor people out in the rural areas beyond Mound Bayou.

The blacks in the farm country outside Mound Bayou were accustomed to suffering the pain of their illnesses until it became unbearable. Only then would they seek out a doctor. Even if the doctor was black, he would frequently demand payment on the spot; and if he was white, he would often only talk to them across a desk, asking questions. And if the illness required a number of trips to the doctor, the bills piled up, to be paid in dollar dribbles that inevitably lost the race between reaching final payment and the arrival of the next health crisis.

The Reverend Arrilis Biggs stood in the doorway of the small country church in Round Lake—a poverty-sunk, cotton-growing community in Bolivar County—shaking hands with his departing Sunday worshippers. His sermon this day had again been on the Tufts health project and its regional health council, on which

he himself served as one of the two district representatives from Round Lake. As such it was the Reverend's responsibility to go among the people and listen to their complaints, then report them to the council. Today, again, he had explained to his people what the program could mean to each of them, to their whole community.

Biggs is only a part-time preacher (the rest of the time he works hauling cotton-pickers and loads of firewood), but his message this Sunday, he was confident, had truly got through. Now he was thinking ahead to the council meeting scheduled for that afternoon at the health center.

An old man approached. The Reverend Mr. Biggs focused on the gray-stubbled face, took the man's hand and gave it a gentle squeeze.

"My wife's sister died on Friday," the man said. "A lot of relatives'll be comin' from California. We're gon' hold the funeral off till the end of the week 'cause they'll be drivin'.'

Biggs reached into his pocket for his wallet. There were two dollars in it.
He gave one to the old man. "Take this,' he said. "You can buy a chicken . . . put some gravy on it."

When everyone had gone, Biggs limped back into the church, took off his black robe and put on a worn suit jacket. He went outside and got into his pickup, a tattered Humphrey-Muskie sticker still on the tailgate, and drove off toward Mound Bayou—20 miles away.

A regular Tufts workday begins at 9 a.m. and may end 16 hours later. The social workers, public health nurses—assisted by nurses' aides—and the environmental illuminating the worn threads of their best Sunday clothes, accentuating the deep lines in their faces and along the backs of their work-scarred hands.

Hatch rises to greet them. He gets down to business and they listen. On some of the delegates' faces is the "zero look"—that blank, bottomless, benign expression which all their lives has disguised, from white people and strangers, their real feelings. It is there now, but they do not mean it; it has simply become a part of them.

"Jobs alone will not solve our problem," Hatch tells them. "We need psychological uplifting as well." He looks down at his muddy-soled shoes, feels the sagging weight of his heavy forearms and shoulders. "Nobody's going to just give us anything." His finger punctuates his point—that they themselves must make the gift grow. "How many times has anybody knocked on your door and said: 'Here's a job. Here's some money.'" They shake their heads indicating never. "To free ourselves we've got to think like money's no problem—though it is. Sometimes you've got to think like you're Rockefeller!" As one, they nod their heads and smile. Occasionally they pat their feet in agreement with his words.

Hatch catches his breath and goes on in his gentle, hands-gesturing manner. "I don't know how I learned anything at the high school I attended. It had no books, no library, no laboratory. Nothing. Now, we don't want that for our children. We're here to talk about what we need to do to straighten things out."

With a sigh he sits back down, for a while they all just sit in loose-jawed silence, staring—first at him, then at the temporary chairman of the meeting, the Reverend Mr. Biggs who sits up front near Hatch. Finally, a heavy-set, alert-looking woman with gold caps on her front teeth stands up. She is Mrs. Pearlie Mae Robinson, the Reverend Mr. Biggs' fellow delegate from Round Lake. She addresses John Hatch.

"You ask us what we need. We need so much we hardly know what to say. Where to start saying what we need." She graciously smooths her dress beneath her and sits back down.

Hatch is on his feet again, folding his hands one inside the other, making a half-cup of them. He remembers the broken pecan nut in his coat pocket, takes it out and absently fingers it—the sweet, soft fruit inside that hard shell. He puts the nut back in his pocket.

"We need a nursing home for our older people," he says. "Recreation for them—movies, bus trips, fishing trips. Time hangs heavy when you're older." They stir in their seats. He has struck a deep chord. "And we need things for our young people—junior health clubs, supervised study halls, educational films, libraries." Suddenly—in mid-sentence—he halts, aware again that if they are to grow strong, if one day they are to be able to function independently, he must let them do the thinking now, the planning, the dreaming. He sits again.

The Reverend Arrlis Biggs get up, his dark face a mixture of rage and anguish. "As temporary chairman of this meeting, I'd like to say that I think Tufts is the

pretty good answer to some prayer that poor people could get help." They all nod at him and he stands taller; his torso seems to expand. "Look here, I don't want my son to be stomping around in my little tracks. I want him to go on to better things—to grow up an' be somebody!" He sits.

Now a balding man from Gunnison, dressed in an ancient double-breasted salt-and-pepper suit, gets slowly to his feet. He turns his head deliberately as he talks, addressing everyone. "I didn't have the slightest idea of what could be done through a health project. Listenin' to Brother Hatch here talk about how we can improve ourselves gives me a little more courage to take back home with me."

A gentleman from Duncan gets up. He clutches his hat in both hands and presses it against his chest. "I've lived my whole life in Bolivar County an' ain't nothin like Tufts ever happened before to help poor people. I love my mother, but if my mother was to pull away from Tuffs tonight, I wouldn't follow her as far as that back wall there." An embarrased silence.

Finally some other people talk, and then Hatch again—and then they begin to work out a budget to accomplish some of the things they need. Pretty soon the meeting ends, then all stand and the Reverend Mr. Biggs prays on them; and they sing from memory "Precious Lord, take my hand. . . ."

It has grown dark outside the health center. The gray Mississippi sky broods beyond the silhouetted cotton fields. And in the air is the same intangible terror they have felt all their lives on dark Delta nights—the whispering ghosts of dead black men who haunt the vine-tangled trees beyond the levee. But this night again there is less foreboding, less heaviness of heart as they make their way back to their shacks. They believe they are going to survive.

EXHIBIT D.—HEALTH CENTER IN MISSISSIPPI, BY H. JACK GEIGER, TUFTS UNIVERSITY

The Tufts-Delta Health Center recently moved into permanent quarters. Fresh and shiny in the Mississippi sun, the one-floor structure embodies advanced refinements of design to support family-centered group practice. It stands in a cotton field, a symbol of the future amid relics of the plantation economy. The location epitomizes our relationship to the 14,000 desperately poor people we serve in a 500 square mile area of northern Bolivar County: We are where they are—in the field. They know where to find us, and we them.

It might be easier for a stranger to locate Mount Everest than Mound Bayou. the town nearest us (population 1,500). But no matter. That's instructive, too. Believers in what we call the "Mount Everest fallacy" contend that the poor, both black and white, can get medical care of the best technical quality and that if they don't it must be their fault. But imagine a wonderful medical center, open to rich and poor, atop Mount Everest. If the only regular patients are Tenzing Norkay and Sir Edmund Hillary, obviously the rest of the world is apathetic and uncooperative. Sounds abusrd, doesn't it? Yet many of our nation's health services for the poor are divided from them by barriers—of time, distance, inadequate transportation, loss of a day's pay, lack of a baby-sitter, complex eligibility requirements, impersonality, fragmented service, and the stigma of "charity."

So—we work in the cotton fields. On a map, look for us 100 miles south of Memphis along U.S. 61 in the Mississippi Delta where the bolls fleck white through a persistent asthmagenic haze of dusted crops or the smoke of burning manure. The monotony of sky, smoke, dust, flatlands, and cotton makes it hard for the visitor to discern the people from afar. Machines seem more indigenous. Field hands appear to be black specks either saddling the mechanical pickers or stuffing trailing white bags as they pluck cotton by hand for a few dollars a day. Weatherbeaten shacks cluster by dirt roads, their windows stuffed with paper, their tin chimneys askew. Some dwellings are vacant but many, also decaying, show a curl of smoke, an oldster bending into the light from a doorway or sitting, chin on cane, on a sagging porch, and children dodging in the yards among the outhouses.

You reach Mound Bayou on U.S. 61 through tiny towns called Alligator, Duncan, and Hushpuckena. Northern Bolivar is part of what "Dixie" recalls as the "land of cotton." Old times there are forgotten. For decades many natives have voted—with their feet—by migrating. The mechanical picker, deepening the ancient poverty with unemployment, drove many young people to the northern cities. In the last decade, one in seven Bolivar Negroes went, leaving behind high concentrations of the old, lame, blind, sick, young, and the bewildered. Every June you

can see young people at the bus stops, saying goodbye, some with high school diplomas in their bags, going North. Today, northern Bolivar's 12,000 Negroes are 75 percent unemployed, have an average anual family income of $900 per annum, an infant mortality rate of 60 pre 1,000 live births (four times that of affluent Americans but less than the 100 per 1,000 in some urban tracts), hunger, bad housing, and other problems spawned in the social, political, economic, and racial climate of Mississippi.

In November 1967—after almost three years of planning, field work, struggling to create an adequate facility—the Tufts-Delta Health Center began clinical service in a remodeled church parsonage in Mound Bayou, an all-Negro community founded during Reconstruction. Operated by Tufts University School of Medicine under a $1.2 million grant from the U.S. Office of Economic Opportunity, the center is a "younger brother" to one Tufts operates in a Boston low-income housing project, Columbia Point. The two centers—first of what is now a nationwide network of OEO health centers—sit at terminals of one of America's great human migrations.

The Tufts-Delta center demonstrated from the outset a determination to learn from its environment and adapt to it. In the personage, a desperate improvisation because of delays in construction, bedrooms became examining rooms, the kitchen a laboratory, the living room a waiting room. A rundown movie threater became a school for training aides. A prenatal clinic was set up in a storefront. Space in a Sunday school building was turned into staff and nursing offices. Professional staff came from Tufts and other nonsourthern institutions, but many were recruited from among southern-born, northern-trained Negroes who wanted to return to the South. Today, 32 of 44 professional and technical positions are held by Negroes, many from Bolivar itself, as are almost all of the subprofessional posts. For instance, Bolivar women were trained as nurses' aides, receiving $65 a week, or triple what they earned at cotton picking when that work was available.

In May 1967, the center moved into an intermediate, prefabricated building in a cotton field about one-quarter mile from U.S. 61 in Mound Bayou. Last December it expanded into a 24,000 sq ft structure that expresses our basic medical strategy: comprehensive medical care through group practice, integrated with sanitation, environmental improvement, and community organization. The eastern half of the building has corridors along which are offices of the three family health care groups, each comprised of an internist, pediatrician, general practitioner, community health nurses, social workers, medical asistants, nurses' aides, and sanitarians. An obstetrician-gynecologist, a surgeon, and a psychologist serve all three groups. In the western half are an emergency room, a plaster room for fractures and trauma facilities for performing nomal deliveries and for training local midwives (43 percent of Bolivar births now are attened by relatively untrained midwives), x-ray facilities, record room, lab, and pharmacy.

The buildings in the cotton field represent only the visible skelton of our relationship to the people. The center has helped organize community health associations in 10 Bolivar towns and rural districts in our service area. All our target population is represented through them on the North Bolivar County Health Council. The council and associations are avenues of popular expression about—and local participation in—health services and needs. Eventually, the council will share completely with Tufts in the planing, management, and direction of the entire program. For example, these organizations of the poor themselves are forming transportation and communication networks to assure that the sick get to the center and that center personnel know where to go to reach the sick.

Through community organizers, sanitarians, community health nurses, nurses' aides, social workers, environmental improvement workers, physicians, and others the center reaches out to the entire area. We have completed a full house-by-house demographic census. One-third of the target population has answered a structured health interveiw. We have benchmarks on race, sex, age employment, occupation, income, education, family structure, housing, sanitation, migration, health and illness, and health services utilization. The analytical work took two of the three years' preparation before clinical service began.

In reaching out, we found people with seemingly endless unmet medical needs. Some stark conditions had existed untreated or undiagnosed for decades. Some were straight out of 19th century textbooks of infectious disease. We found everything one would expect: infections, malignancies, heart disease, endocrine disease, especially high rates of hypertension in adults and infectious diarrhea in children.

To meet the shortage of hospital beds, we often made people patients in their

own homes. We put hospital beds in shacks, repaired the environment, and assigned physicians and nurses to make rounds. As an example of what we found could be done (virtually hospital care outside the hospital) let me cite the case of elderly Mrs. Sally Jones. Injured in a shotgun accident, she had head wounds, brain damage, and one eye lost. She had been to one of the big Mississippi hospitals for neurosurgery, and after five weeks she was discharged It's not clear to us or the family whether the hospital tried to make any provision for her continuing care. In any event, there are pitifully few chronic disease beds for Negroes in the state.

The family somehow brought her back 180 miles to their dilapidated shack on a plantation 10 miles out of Duncan, a small Bolivar town. She lay in an old, sagging bed in the four-room structure housing 11 people. On the first day, the family sent us frantic appeals for help. We found Mrs. Jones apparently hemiplegic, aphasic, with 102 degree temperature, pneumonia, a nasogastric tube and urinary catheter hanging out. The family, devoted and eager to care for her, neither understood nor had the equipment for tube feeding or bladder irrigation. There was no equipment for bed care. The Delta summer heat was unbearable.

From our stock of surplus beds at the center, we moved a railed hospital bed and equipment for tube feeding and bladder irrigation into the home. We instructed the family on using it. We treated the pneumonia and bladder infection. Our environmental improvement unit helped the family screen the house, repair the floors, fill the holes in the walls and roof of Mrs. Jones' room, and make the water supply safe. As her condition stabilized, we removed the nasogastric tube. The family began spooning water and soft food to her, oh so slowly. Her swallowing was limited. She began to eat soft food, then regular food. Meanwhile, we took out the urinary catheter. She was continent. Testing showed that with intensive effort she could speak. We began working on that. It became clear she was not hemiplegic but hemiparetic. The family scrounged a wheelchair and we taught them to exercise her. Subsequently, she started walking with a three-point cane. All this was accomplished primarily by nurses and nurses' aides and the family.

That was in July. In October, Mrs. Jones walked into the center and said "Good morning, doctor." She still has a long way to go .She needs tendon transplants, intensive physical therapy, and rehabilitation. But she has every prospect, if we can manage all this, of being restored to useful life despite deficits, particularly speech. I never would have believed such a patient could survive outside a hospital.

Unfortunately, Bolivar County Negroes are at the base of Mount Everest when it comes to basic as well as advanced hospital care. Among the prime barriers is segregation. When we arrived in 1965, Mount Bayou had two small, all-Negro hospitals put up by fraternal orders decades ago, when almost no hospital beds were available for nonwhites, out of the nickels and dimes of sharecroppers. Both were in desperate financial straits and both had major problems of examining facilities and equipment. Working together with Tufts and with Meharry Medical College, Nashville, Tenn., which had helped the area for 20 years, the two small private hospitals merged, formed a voluntary community hospital, and obtained a major grant from OEO to provide free hospitalization for the poverty population, create a new dental program, and upgrade its staff and facilities. Health center physicians double on the hospital staff, which is steadily growing with help from Meharry. Now there is hope for a new community hospital building, to be built with federal aid in association with the health center.

At present, however, we send complex cases 100 miles to Memphis or 140 miles to Jackson, even though 10 miles away is the 101-bed East Bolivar County Hospital, which has complete facilities including a pathology laboratory and premature nursery and JCAH accreditation. But it is not in Medicare because of segregation practices, and no federal money can be spent there except for emergency care.

Besides segregation, there is a money barrier: Many Mississippi hospitals require a $50 deposit before admission, effectively precluding use by a great majority of the Negro population and many poor whites.

Georgraphy and other factors make big differences in the way a health center relates to hospitals. Our Columbia Point Health Center, serving 6,000 persons in Boston, is within a 15-minute drive of 18 teaching hospitals. It takes two hours of hard driving to reach a teaching hospital in Memphis from Mound Bayou. In

either Mississippi or Massachusetts, the health center serves as the patient's protagonist, eager to continue or reassume responsibility from the teaching hospital for the patient's care.

In the urban setting, the center must coordinate the work of various hospital specialty clinics and that of physicians. The rural center has virtually no outside services—fragmented or not—to work with. Bolivar lacks physicians (34 per 100,000 in the county vis-a-vis 77 in Mississippi as a whole and 140 in the U.S. generally); it lacks third-party funding of services, transportation, and special hospital services. Thus the rural center by itself must constitute a big slice of a health care system. The Tufts-Delta center tries to do everything possible on an ambulatory or home basis.

In a significant way, the Tufts-Delta center's task is to generate hospitalizations, while that of the Columbia Point center is to reduce the use of hospitals. The Mississippi population has many untreated illnesses requiring hospital care. At Columbia Point, after the first two years of center activity, in-hospital use declined by 80 percent because the health care was available early, under a single roof, and within walking distance of the home. The 80 percent statistic derives from a study of 54 families in the year before the center opened and in the two years since. In 1965 these families used a total of 200 hospital days, with stays averaging 8.3 days. In 1966 they used 110 hospital days, averaging 5.5 days per stay. In 1967, the second year of center operation, they used 40 hospital days, averaging 5.0 days per stay.

These and other data suggest that by stressing comprehensive care, the family approach, group practice, and environmental responsibility, centers are providing better care for less expense and effort. To elaborate on the environmental aspect: In Bolivar, our environmental improvement unit (directed by Andrew James, who holds an M.S. degree and is the first Negro sanitarian in Missisippi) has helped whole communities to organize water corporations and obtain federal help for protected water supplies. In some communities people drink from drainage ditches. We improvised a machine to dig safe wells. We razed abandoned shacks, using the wood for new privies and for home repairs on occupied houses. The unit cleans up garbage dumps and kills rats.

The center's interest extends to other activities, since we believe that medical activity alone is not enough. We hope to help develop a pre-Head Start program in Bolivar; some rural Negro infants appear so deprived that they are afraid of toys they see for the first time. A work-study traineeship program in the center for Negro high school students gives them contact with Negro professionals and may influence the youngsters' further education. Two Mississippi Negroes and one from Alabama are now in the freshman class at Tufts University School of Medicine. Two of our Mississippi Negro staff are headed for social work training in Boston; others are being helped by the center to obtain training as practical nurses, sanitarians, and in other professional roles. In five years we hope the center will be staffed and directed primarily by Mississipians.

The philosophy behind these educational and environmental activities is that the health center is a community institution based on health services but oriented toward broader types of change, particularly by involving people in activities that change their attitudes, knowledge, and motivations. Center health associations give the communities a voice in management.

As a major example, the Tufts-Delta center stimulated the formation of the North Bolivar Cooperative Farm, a 120-acre farm on which the 800 poorest and hungriest families in the area pooled their efforts in one season to grow a million pounds of snap beans, Irish potatoes, sweet potatoes, collard greens, and other foods for Bolivar's hungry. This year we hope the farm will expand to 500 acres, and funding is sought for a cannery to process the surplus for marketing to northern Negroes who want southern "soul" foods. Thus Bolivar will have a new industry to take hundreds of people out of the starving cotton economy.

Another point of unity between the Tufts-Delta and Columbia Point centers is that they cover both ends—the rural source and the urban terminus—of one of this nation's great internal migrations, the flow of Negroes to the North. Columbia Point's Negro population came from places like Bolivar County. Knowledge gained at one center is applicable at the other. Columbia Point workers will benefit from a knowledge of family and institutional life in rural Mississippi and can better help migrant families adjust to the North. In return, so long as Delta people continue to leave for the North, the Mound Bayou center at least helps assure that they do not arrive in wretched health or totally devoid of marketable skills.

These are only some of the dimensions of what is not always regarded as the proper role for health professionals but which to me are basic if a comprehensive health care job is to be done. The centers carry out the idea that health services are valuable not only in themselves but as a point of entry for other kinds of efforts, such as economic development, education, job training, housing, and so on. Health professionals today need to rediscover the social commitments of their forebears of a century or more ago. They were leaders in the fight for sanitary reform, for an end to slum housing, for abolition of child labor. Today's crises—slums, hunger, rat bites, illiteracy, and discrimination—demand the same response.

My office in the intermediate building at Mound Bayou had an exit door to the outside. It was labeled "Emergency." In case of fire, you could run right out into the cotton field. Someone suggested it open into the building. The "emergency," after all, is outside.

Exhibit E. Health Care in the Mississippi Delta

(By Cynthia Kelly)

Three of us—a community health nurse, a licensed practical nurse, and a city visitor—jounced along in the mud for 10 minutes before we realized that the bumpy ride was not all due to the washboard ridges of the gravel road. Our left rear tire was flat. Nothing moved in the rain-drenched Delta landscape. Acre upon acre of farmland stretched flat, brown, and empty as far as the eye could see.

Estelle Rodriguez, community health nurse, trudged back half a mile to a group of dilapidated houses. One was painted—it might have a telephone. It did not. As we were deciding who should walk the mile ahead to another cluster of shacks, a car appeared on the horizon. Presently it slowed to a halt beside us. Three men changed the flat tire in minutes and we resumed the 10-mile trip to the second patient of the day.

As some of Mississippi's most fertile land sloshed past, Mrs. Rodriguez explained that the "dwellings," huddled by twos and threes or isolated from one another by miles, were homes to the people of Bolivar County whose only way of life for centuries had been harvesting cotton. When machines replaced men in the cotton fields, she said, these rural people lost their only livelihood. Plantation owners let them follow the mechanical pickers and collect any bits of cotton it missed, but the take is not enough to support families of 10 to 12. So the young, strong adults have migrated north or west to seek work.

Those who are too old, too weak, or too young to leave make up most of the 12,000 persons comprising the case load of Estelle Rodriguez, 7 other professional nurses, 3 licensed practical nurses, and the 15 aides who are the nursing staff of the Tufts-Delta Health Center in Mound Bayou, an all-Negro, 70-year-old hamlet of about 1,400 persons. Since the center opened in November 1967, funded by the Office of Economic Opportunity, these nurses, together with physicians, sanitarians, social workers, nutritionists, community organizers, and others have created a broad community health program where virtually none existed.

The center's staff is recruited and its work directed by a team from Tufts University Medical School, Boston, Massachusetts. Of the 26 members of the nursing staff, 21 are long-time residents of the center's 500-square-mile "district," the northern half of Bolivar County in northwest Mississippi.

Clementine Murray, nurse's aide, is a lifelong resident of Bolivar County who was trained by the nurses and physicians at the center. The mother of 9 children ranging in age from 6 to 18, Mrs. Murray says she is able to manage her home and a full-time job assisting the center's surgeon because she wants to. "When I was little, my schoolteacher said, 'Don't you hang your head down and say I can't. Hold your head up and stick out your chin and say, I can if I want to.' "

Months before the present superbly equipped Tufts-Delta Health Center opened. Mrs. Murray took the nurse's aide course in an abandoned movie theater. At that time, clinical services were offered in a remodeled Mound Bayou church parsonage whose bedrooms were converted to examining rooms, kitchen to lab, and living room to waiting room. Then the prenatal clinic was conducted in a storefront by two nurse midwives, Sister Mary Stella Simpson and Aase Johansen. Medical and nursing offices were rented from a Baptist Sunday School.

Estelle Rodriguez, associate nursing administrator of the center, spends a day or so every week in the field with one or another of the licensed practical nurses

or aides helping them care for persons whose health needs are almost unlimited. On this particular cold February morning, Mrs. Rodriguez already had looked in on a 32-year-old mother of 10 children who had suffered a stroke and just recently returned home from the Mound Bayou Community Hospital, a 50-bed facility near the center. Mrs. Rodriguez found the nurse's aide bathing the patient, and a homemaker—another local resident trained at the center—supervising three preschool children as they swept the three-room house and preparing their noon meal.

From this patient's home, we drove north to Shelby, population 2,300, to hunt for a newly referred patient in an outlying area. Ora Bowie, licensed practical nurse, inquired at the post office, questioned a passerby, and knocked on several doors. No one knew the whereabouts of the woman we were trying to locate so the hunt was abandoned.

"Tomorrow," Mrs. Rodriguez said, "I'll try another little town where they're very good at locating people." Once a patient's home is found, a simple map is attached to his record at the center indicating the route—by ditches, bayous, or hickory tree.

The patient we visited after our flat was changed lives with his mother, sister, and nieces and nephews in a typical home, a house made of boards, unpainted, without foundations except for piles of rock supporting its four corners, surrounded on rainy days by ankle-deep mud; in dry weather by dust. The main room, where grandmother, son, daughter, and two toddlers were staying close to a small stove, was spotlessly clean and slightly warmer than the outdoor temperature of 43 degrees. The walls were papered in brown wrapping paper. The bare wood floor looked freshly scrubbed. The "primary" patient was 30 years old. Seven months previously Mrs. Rodriguez had found him in severe acidosis, put him in her car and driven him to the center. Today he felt and looked "just fine." When Mrs. Bowie tested his urine, it showed no sugar.

"I got a job, ma'am," he said proudly, "driving a truck."

"That's great," Mrs. Rodriguez beamed. "How many of you are living here?"

"Eleven," the grandmother answered.

"And how many rooms have you?"

"Four rooms."

"Do you live here rent free?"

"Yes, we do." Later Mrs. Rodriguez explained that when field hands' shacks are vacated due to death or migration, another family immediately moves in and counts itself very fortunate to exist there rent free.

There was no water, no telephone, no indoor toilet, and only the small wood-burning stove for heat. Two 1969 calendars, each with a picture of Martin Luther King, Jr. were the only wall decoration. Dr. King's photograph and the stove were the two items common to all the homes we visited.

Two panes of glass were missing as well as the doorknob section of the front door. Mrs. Bowie promised to send a repair man from the center with glass to replace the cardboard covering the window.

Mrs. Rodriguez asked the young mother to have the year-old baby ready the next morning for a trip to the center so that a doctor could examine his swollen eyelids. "The ambulance (a station wagon) will pick up you about 10 o'clock."

Two-year-old Johnnie was undressed so the nurses could see how well his buttocks had healed. Several weeks before Johnnie had backed into the stove and suffered deep burns. He and his little brother observed us silently, their eyes almost blank. Later, the nurse suggested that the flat expression of many Delta youngsters may be partly due to their seeing almost no one besides their immediate families, partly to the retardation that comes from chronic malnutrition.

At 4:30 P.M. we were back in Mound Bayou after a round trip of 78 miles to see four families. Mr. Greenwood, an 80-year-old man, bedridden in a room papered entirely with newspapers since his stroke in 1967, had had a fecal impaction removed. His wife was now giving him a bowel softener to supplement his daily prune juice. Mr. Greenwood's skin was smooth and supple, evidence of unending back rubs with mineral oil or "drippings when we can't buy oil." His left arm was fixed in extension with the hand rotated at an acute angle, ankylosed long before he had become one of the center's patients. A neighbor dropped in to see what the nurses were doing for the Greenwoods and promised to assist Mrs. Greenwood in getting her husband out of bed. She reported that a young mother nearby needed "that nurse in Catholic dress" (Sister Mary Stella, nurse midwife).

Another home, affluent by comparison, had outbuildings that housed farm tools, a stove large enough to warm two rooms, walnut-framed photographs of ancestors, and an all-pervading odor of chitlings cooking for dinner. Since the patient's urine sugar test proved to be negative. Mrs. Rodriguez agreed she might have "a few bites of chitlings" for dinner. "Miss Annie's been so good about her diet, she deserves a reward."

Annie Wilson has bilateral below-the-knee amputations. Removing the pillows from under Miss Wilson's knees, the nurse explained the importance of keeping her legs straight so that soon she might be fitted with artificial legs.

For many years, Miss Wilson had kept house for her brother on a farm which he owned. When he became ill, she nursed him for more years. The couple who now care for her in their home had been the Wilsons' lifetime friends and closest neighbors. The night Mr. Wilson died, his sister called these neighbors the only way she could, by going outdoors and firing his shotgun.

When the health center was being planned, the staff anticipated being overwhelmed with children. Actually, the nurses say they see many more geriatric patients, then pediatric "but its *people* from the cradle to the grave, and every illness in between."

Miss Wilson, Mr. Greenwood, the young mother with hemiplegia—all had hospital beds, bedpans, urine testing sets, incontinence pads, and so on. Since the Mound Bayou Community Hospital accommodates only 50 patients, the center tries to provide equipment for families to care for their relatives at home whenever possible. H. Jack Geiger, M.D., project director, hopes soon to have "nine acute home care packages consisting of a nurse's aide, a chemical toilet, 50 gallons of pure water, a portable water heater, a washing machine, an I.V. stand, and the like so that we can move into a home immediately when there are no hospital vacancies."

The community hospital and the health center are partners. Viola Chandler, director of nursing at the hospital, recruited Thelma Walker, the nursing administrator of the center. Together they coordinate nursing care from the rural district to the center or the hospital and back to the community; develop inservice programs for both their staffs; and pool their experience with community and hospital resources to benefit patients and personnel. Mrs. Chandler and Mrs. Walker have already instituted a rotation program between the two agencies. A center registered nurse is refreshing her knowledge of acute care during a three-month assignment at the hospital while a hospital staff nurse becomes acquainted with the outreach programs and clinics for ambulatory patients at the center.

Asked what differences she sees between nursing at the Tufts-Delta Health Center and her previous public health nursing, Thelma Walker states the biggest difference arises from the transportation problems of a scattered population living under almost primitive conditions. "Dogs, dust in summer or mud in winter, and distances slow us down. On the other hand, the local people, through the community health organizations, are helping enormously by transporting patients to clinics."

Mrs. Walker says in comparison with her former experience she now sees more mothers with toxemia, with eclampsia, more children with rheumatic fever, with diarrhea, more people of all ages with iron-deficiency anemia, and more elderly persons with ankylosed joints following cerebrovascular accidents. "But we have more resources right at hand in the center and the community hospital than I've ever had, too. If a nurse in the field finds a home without a water supply—some families have carried every drop for miles all their lives, some have scraped the scum off ditches and used the water underneath—out go the sanitarians and engineers with the well digger invented right here at the center and they dig a well in half a day. If there are rats coming through the floor, we exterminate them. A leaking roof? A privy falling down? Out go workers from the center—and these are local people—to patch the roof, build a new privy or take healthy adults tools from the tool bank we've scrounged together so they can make their own repairs."

To the question, "Don't you ever become discouraged and have the feeling that all your efforts are only drops in a bottomless bucket?" Mrs. Walker's reply, like Dr. Geiger's, Mrs. Chandler's, and many others', was a resounding "No." Mrs. Walker cited the changing patterns in maternal-child care. From an almost universal lack of any prenatal care three years ago, the trend now is to attendance at the center's antepartal clinic, often before the fifth month

of pregnancy, delivery in the community hospital, postpartum follow-up, and protection of infants from birth on. "Quite a change," she says, "from the days when Sister Mary Stella and Aase Johansen saw many mothers for the first time when they were ready to deliver—or had delivered—and from the time when little children never saw a doctor or nurse until they were so ill with diarrhea or pneumonia that it was touch and go to save them." The two nurse midwives have helped in prenatal care or delivery of over 100 babies, all living, many at home, but now most mothers have their babies in the hospital.

Dr. Geiger cites the strides taken by the residents of Mound Bayou and all of northern Bolivar County. He says that when the center first opened the most pressing need was survival. "Pills without food were useless so we stocked food in our pharmacy on the theory that the specific treatment for malnutrition is food." As an even better way to put these elements together, Geiger continues, the center helped the 800 poorest and hungriest families—those with yearly incomes of $200 or less—to form a farm cooperative and obtain, through Tufts, a grant from the Office of Economy Opportunity. With this start-up money, they rented 120 acres of unused land and pooled their labor to grow food instead of cotton. "In one spring and summer, they have grown one million pounds of food, enough to end hunger in Northern Bolivar County—sweet potatoes, Irish potatoes, snap beans, butter beans, black-eyed peas, collard greens and the like." With help from the center the farm cooperative constructed a makeshift freezing plant to store food through this winter and set up a distribution system. This year promises to see 500 acres under cultivation and possibly a full-scale cannery in operation. Besides growing food for Bolivar County residents and a crop to export, the farm cooperative may thus provide a whole new industry, with hundreds of jobs under local direction and ownership. The co-op is run by its own elected board of directors, chooses its executives and personnel, and is training a director, cannery manager, and so on.

"Indeed I'm not discouraged," Estelle Rodriguez says. "When I see old folks taking heart again and young people who left home in despair beginning to come back—as engineers or sanitarians or nurses—or when I see all these nurses' aides becoming such fine, capable helpers to the sick, I'm nothing but *en*couraged."

"But what about the practical difficulties? How do you teach a woman with hypertension who can't read or write and who's always eaten salt pork to follow a low sodium diet?"

"Not hard at all," Mrs. Rodriguez explains. "I show her how to trim the fat off her pork, how to lift the greens up out of the fat instead of dishing them out swimming in fat. This doesn't make her diet letter perfect, but at least it reduces the cholesterol and the salt. Another thing—you noticed trash outside some shacks? Did you also notice there weren't many tin cans? Well, these people eat the good green, fresh vegetables that the farm co-op is growing. Much less sodium than canned food."

A vistor might be discouraged. But visitors never knew the community before the Tufts-Delta Health Center helped it tackle—and overcome—its most crushing problems. What part have nurses played? Geiger answers this question indirectly when he says he would give "two orthopedists and a good-hitting second baseman for one good community health nurse in the field." Why? "For follow-up, for case finding, for clueing everyone else in on the home setting, for compensating for shortages of doctors, for helping interrupt the idiot revolving-door game, the old business of diagnosing, treating, and sending a patient right back to the environment that produced his illness.

The history of an 11-year-old boy illustrates Dr. Geiger's opinion of the value of community nurses. Bobby was seen in the center's pediatric clinic because he had symptoms of an acute abdominal disturbance, the very common complaint stemming from a variety of causes—poor diet, impure water, low resistance to infection, and so on. Bobby was given ampicillin and sent home on this drug, to be visited daily by the community health nurse. At the first visit, Bobby's mother assured the nurse that he was better, but the nurse was not wholly satisfied. During her second visit, the nurse's questions revealed that the mother had given Bobby ampicillin only when he had pain, not on the prescribed regular schedule. The child was still really ill. The nurse's report to the physician led to Bobby's immediate hospitalization and an operation for intestinal obstruction.

The strongest testimonial is often that which is not solicited. During this reporter's interview with Mrs. Walker, a physician interrupted because he was anxious about a woman he had been unable to see that day. "I went to her home

and knocked and called, but the door was padlocked on the outside. This old lady is locked in, all alone. Could one of the nurses stop by?"

Mrs. Walker arranged for the visit and said, "Often when an elderly person is ill and the rest of the family works or goes to school, they lock the patient in for protection until they get home. But if a nurse goes out and identifies herself, usually the patient will poke the key out a crack in the wall or a window so the nurse can unlock the door and get in." Apparently, nurses have proved to patients in the cotton fields, as in "the field" the world over, that they come only as helpers.

ITEM 2: A LOOK AT THE ELDERLY POOR IN THE SIX-COUNTY TARGET AREA IN CENTRAL MISSISSIPPI PROJECT "FIND" INTERIM REPORT JUNE 1, 1968–SEPTEMBER 30, 1969 (QUARTERLY REPORT SUBMITTED SEPTEMBER 30, 1969) CENTRAL MISSISSIPPI, INC. PROJECT "FIND," WINONA, MISSISSIPPI, JAMES E. WLLIAMS, PROJECT DIRECTOR[1]

INTRODUCTION

Project FIND is an action-research demonstration program administered by Central Mississippi, Inc. through a grant from the Administration on Aging and sponsored by the CAP Agency in Winona, Mississippi, and serving the six-county area comprised of Attala, Carroll, Choctaw, Holmes, Montgomery, and Webster.

These counties have a total population of 94,000. Included in this population count are 12,000 senior citizens whose ages range from 65 years or older. There may be added to this group 5,000 people between the ages of 55–65 who must be included in the above grouping due to health, handicap, or retardation. This will increase the total group of elderly poor to 17,000 individuals.

These people live in the rural areas where there is no township with as many as 10,000 people.

Almost all of the elderly poor are the result of a tenant farm system operated on unfertile hills hardly suited to profitable production of row crops. In spite of this, these people have remained on or near the soil of their birthplaces.

The erosive symptoms of the so called American and Southern way of life has compelled many of the elderly poor to fall down into what seems to be the bottomless pit of poverty.

The above statement may be amplified many times because the Negro or Non-White elderly poor must suffer from the triple jeopardy of RACE—AGE—and POVERTY.

There is much to be said of the "Challenge of Change" where many of these "Old Grannies" have spent their lives in poor paying domestic servitude being turned away to drift back from whence they came—no longer able to serve they are cast to the bats and owls and general ravages of time.

Finally who are these people that we call the elderly poor?

These are the people that time has over-run, the people that cannot keep up in a demanding society' These are the people that present poverty as a plague and incurable disease.

Where are they found? They are found from one end of the target area to the other—on the hilltop—the foothill—the valley—on narrow trails that lead to the broken down homes and dilapidated shacks with leaky roofs that the poor call their home. Their homes are no places of beauty—rather a haven for rats, mice, flies, and other insects which these people find hard to control. These people are the left-over of our great society.

OBJECTIVES

The purpose of Project FIND may be combined into a rather unique program reflecting research services and social action components. However, the main purpose of the project is to accomplish three main objectives.

1. To aggressively seek out the aging poor for the purpose of determining their needs, and to provide them with assistance, services, supports, and information together with referrals to existing local agencies and services.

---

[1] See statement, p. 360.

2. To access the local programs and services available to the aging documenting the many gaps to be found wherein there is clearly demonstrated an existing need to make recommendations for improved services.

3. To involve the aging, or elderly poor in self-help and social action programs mainly through community organizations.

Objectives may be further simplified as follows:

1. Locate the elderly.
2. Determine resources.
3. Make friendly visits.
4. Escort the sick.
5. Telephone reassurance.
6. Make home repairs.
7. Refinish furniture.
8. Furnish homemaker services.
9. Furnish home, health services.
10. Provide shopping services.
11. Clean house.
12. Provide recreation activities.
13. Make referrals.
14. Secure equipment, such as beds, wheelchairs, and bedside tables.
15. Provide many other services to help their clients.

In order to obtain beter results from the objectives, the following goals were formulated—

1. To locate the elderly poor living in the community.
2. To identify their needs.
3. To recognize their problems.
4. To determine their resources.
5. To refer individuals to existing
    a. Health agencies.
    b. Welfare agencies.
    c. Employment agencies.
    d. Housing agencies.
    e. Legal assistance agencies.
    f. Recreation agencies.
    g. Other agencies.
6. To get facts about the living conditions of the elderly poor.
7. To encourage and organize the poor to give expressions to their needs and aspirations.
8. To provide for social action and self-help programs.
9. To create opportunities for unpaid volunteer services from the aged that can afford to give time and money to the program.
10. To emphasize the responsibilities for sponsoring or assisting in a program for the elderly poor to the following institutions—
    a. The family, the neighborhood, the community, the governmental agencies, fraternal groups, churches, and aged volunteers.

BUDGET

The Project FIND budget for the year 1969 represents $60,000—to extend services that would appear to represent resources far beyond perhaps double the allocated budget. Therefore, it has been necessary that each aide help stretch this amount by developing services which we call self-help projects.

Self-Help defined—Self-Help might best be called volunteer services for it means asking friends and communities to give their assistance. This supplement and support to our program has added strength to the services rendered by Project FIND Aides.

Adjustments and a great cut back in the budget limited our source of supply to the elderly. However, operation has continued. Research and referrals has constantly verified the tremendous task ahead for social work with the elderly.

PROGRAM ADMINISTRATION

The people responsible for projecting and administering the program have grown and developed into one of the Central Mississippi's most capable, coordinated, and highly motivated staffs.

Under the directorship of Mr. James Williams, of Kosciusko, and the newly elected Social Service Director, Rev. Claudell Miller of Kilmichael, and the 59

Social Services Aides in the six-county area, and Mrs. Herring, Secretary and Bookkeeper, Project FIND has reason to be proud of the achievements in their quest of serving the—

*F*RIENDLESS
*I*SOLATED
*N*EEDY
*D*ISABLED

elderly poor in our six-county target area.

BUDGET SUPPLEMENT

An additional supplement to the budget became effective on August 15, 1969. At which time two Itinerant Social Workers were added to the personnel category. These two aides have divided the six-counties, and each serves three counties in an advisory to the aides. Travel allowances were necessary to make these workers available to both aides and clients. These two workers are: Mrs. Mary S. Roberts, and Mrs. Murphy L. Gwin. They are dedicated to their work, and are falling into an indispensible position.

DIRECT SERVICES

In addition to information giving and counseling, such direct services as transportation, escort, shopping, friendly visting, telephone reassurance, commodity food delivery, and letter writing are provided. Information giving and referrals are provided to more than 1500 persons, either from target area interviews, by telephone requests, office visits, or letters from persons outside the target area. Direct services (primarily transportation, friendly visiting, and escort) were provided more than 1800 times (inclusive of some unknown portion of the 1500 persons receiving information giving and referral services.) This rather substantial number of direct services results in part from those respondents who received the same service, as friendly visiting, more than one time while the aide made other arrangements through neighbors and volunteers.

SERVICES PROVIDED OUTSIDE OF TARGET AREA

As a result of telephone and letter requests from outside the target area, 61 individuals were contacted at least once in their home. It is noted that the requests coming from outside the target area were more likely to be of an emergency nature. A significant number of these clients were in need of protective services. Services, needs and follow-ups were treated in the same manner as though the person resided within the target area. As a result many such cases received numerous direct services as well as referrals, and necessitated, a substantial number of repeat contacts.

DOCUMENTATION OF PROGRAM

In order to get facts about the living conditions of the elderly poor, aides prepare questionnaires and case work sheets in an effort to reach the individuals primary problems.

Canvases made by our aides documenting the needs of these senior citizens is proof that the services rendered are essential. These elderly residents failed to stay in the main stream due to lack of education, membership in groups in which society discriminates, apathy and a sense of hopelessness, lack of provisions being made for retirement and old age, lack of acceptance of society for golden age or elderly people.

Many of the Project FIND clients are found to be living alone with no one to tend to them, care for them, or help them in anyway. That is why the jobs performed by the social service aides are important to help these older citizens live a longer and better life.

NEED FOR AN EXPANDED PROGRAM

A reflection of the survey in research and demonstration of Project FIND aides and staff, the need for an expanded program has become more important. Efforts have been less successful than desired to completely fulfill services to entire groups of elderly poor residents of the six-county area. Therefore, expan-

sion must be improved and extended for the benefits of the individual served.

Progress on a full-scale basis is essentially needed to meet the requirements created by the increased number of elderly citizens. The potential is here surrounded with sorrow and distress. An increase in budget would allow salary increases for staff, employment of a nurse, also, handy-man repairmen, captains, additional aides, and additional time for 59 aides.

UP-GRADING PROJECT FIND

The up-grading of Project FIND through the years ahead appears to present a structure resembling a simple object, a ladder, with the rungs neatly scheduling the year and the place to attain benefits for a longer and better life with the knowledge and assistance for the elderly anti-poverty group.

That Project FIND is one of the most needed programs in this target area is evidenced by the many requests through telephone calls and personal visits. It is a must.

SUMMARY OF PROJECT DIRECTOR'S WEEKLY REPORT FOR THE QUARTER—JULY 1, 1969, TO SEPT. 30, 1969

Weeks	Participation		Number of families visited	Referrals	Self-help	Social action
	Aides	Elderly clients				
1	44	438	227	55	54	40
2	48	571	214	43	47	38
3	36	733	215	107	70	70
4	47	583	233	61	48	40
5	34	576	192	48	32	23
6	43	445	207	30	48	62
7	42	546	208	104	54	36
8	46	530	229	55	67	39
9	49	349	277	70	113	115
10	44	384	295	32	52	54
11	42	585	295	40	56	101
12	41	409	249	35	49	28
13	50	480	297	55	57	76
Total		6,629	3,085	735	747	722

SUMMATION.—Aides clearly understand objectives of program. Aides report taking elderly in their homes for short stays. Picnics held for elderly. Many requests made for help which could not be given. Project FIND important in lives of a large number of elderly poor. Organization of 23 block clubs or core clubs for senior citizens. Project FIND workers have case load of clients who desperately need Homemaker Assistance. Project FIND recipients express favorable comments in all six-counties. Each area expresses a constant need for the type services rendered by the aides. Beginning of comprehensive survey. Goal 600 clients to be surveyed or resurveyed for documentation.

Totals reflect different kinds of activities engaged in by clients and aides.

Referral agencies continue to provide cooperation with Project FIND Program, and personnel.

Various projects—quilting, vegetable donations, friendly visitations, escort services, consolations, etc.

Preferred groups for Social Action are Church and Missionary Society.

The above aides completed 46 case studies and ran the total survey from 2 to 206.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

(During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:)

"If there had been time for everyone to speak at the Greenwood, Mississippi, hearing on "Older Americans in Rural Areas" I would have said:

(The following replies were received:)

WILL EASLEY, ITTA BENA, MISS.

That I could not get my Social Security. I tried and tried to get it but could not. I am 81 years old now. I get disability—$36 a month, and also a welfare check of $60 a month. I want to know if I can get my Social Security or not? I would like very much to hear from you. I am in a rural area at this present time. 3 children in school, buying clothes, buying food stamps, paying house rent, light bill, paying for wood and buying gas to cook with. When I get through with my bills every month, I don't have anything left.

CHARLIE E. ERVIN, ITTA BENA, MISS.

The need is for a raise in our check because my medical bill is so high. Rent is $20 a month, light bill is $9.22 a month, gas bill is $6.30 and food is too high. Don't have money for a pair of socks and no clothes at all. I am past social security and look like I could draw my social security. My no. is 426-70-6577. If you can help me with it, please do. I thank you very much because I need it bad to help with my bill and clothes.

MRS. MISSOURI GRAY, GREENWOOD, MISS.

I am one among the group that went to MT-Beulah located At Edward, Mississippi to try to help the needy people that was evicted from their delta homes. The Delta Ministry and the F.D.P. met with us to discuss plans to help the homeless. I answered the call. I saw children hungry, barefoot, ragged, also suffering from malnutrition. It was a terrible sight. Eight hundred of us signed a petition, sent a telegram to President Johnson about the food that was in warehouses. Some of us went to the strip located at Greenville, Mississippi. There they were met with guns also the laws. I did not go to the Air base because it snowing. Let me say some of the people thats advocating for poor people now, wasn't giving it a thought. I mean among our race they weren't concerned about us until the programs was lit. We carried food and clothing to Strike City for the needy. I am not rich but my conditions are much better than others. We followed Dr. King and other Civil Rights leaders trying to make things better. I wrote to Senator Robert Kennedy and others. He came to Mississippi to see for himself. Senators Eastland and Stennis never say anything good about us. Although we have worked for him and others for twenty-five cents per hour. Two and a half cents a pound. How could the people have money. They took what we made. That's why conditions among the blacks are like they are. I know, I have lived here 71 years.

I thank you for investigating the Aging in the State of Mississippi. The welfare recipients do not get enough to live on that's true. As Chairman of WRO of Leflore County, I am aware of the conditions of the poor. Some of the poor would work if jobs were available. Some is too feeble to work.

Some of the programs in Mississippi do not reach the poor as a whole. It would be good if we had good homes for the Aging to stay. It's not enough to feed them five days a week. What will happen to them Saturday and Sunday. I am old, but rather eat where I live.

I wish we could have programs that'll give adults something to do. We are not lazy at least not all of us.

Senator Eastland and Stennis object to everything that will help poor blacks. They don't think we needs help. Our fore parents worked without pay. So did our fathers and now it has happened to us. They says we are not human beings.

Mr. George Wallace is waiting on President Nixon's go ahead signal. He said he was waiting on Mr. Nixon to do what he has promised. I am waiting also because I believe blood will run down the street like rain before these youngsters will ungo what we did. They are not going to stand the killings, starvation, and being mistreated as of old. I once didn't believe that we was hated as of now. I was told by a Japanese lady that the Americans hated us. That was 1960. She said no other other nation loved the whites but us. I am sure we are hated by some but not all. We are the last of everything. Our boys are fighting and dying everyday for the freedom of the Koreans and Vietnamese freedom while freedom is denied us in America. In every war some of my relatives dies for the freedom of others and comes home mamed without freedom and respect. That's hard. We can't go much longer because God is not going to allow us to keep on sinning. Try to be on the right side.

C. R. HUMPHREY, JR., M.D., FAYELLE, MISS.

There are several health-oriented problems that could and should be improved.

Medicare: The basic fifty-dollar ($50.00) first payment should be eliminated. There are several factors (issues) involved. Most elderly (over 65 yrs.) are on some subsistance allowances that are overtaxed already and this long with the 20% fee on visits presents an economic drain on these already overtaxed citizens.

There are several other issues that have been discussed today that should be given more concern: housing, extended care facilities, half-way houses that could be run with skilled nursing care and occasional professional doctor visit (either to the office or weekly checks made by the doctor). Senior citizen housing should be approached with some concern—especially giving services to those who are homeless and live entirely off welfare and social security benefits which need to be drastically increased.

The food stamp program has served a worthy purpose. One of which is that it shows a need for more stamps to be available at a cheaper cost to welfare recipients.

The general level of health care to the aged and underprivileged is at low ebb. This probably is due to several factors—pride, the inability to afford costly services, education, an unawareness of methods used to receive services that are paid for by different agencies and/or misinterpretation of the ways by which services are rendered and means of financing these services.

After careful observation of the Tufts-Delta Health Center and Mound Bayou Community Hospital, both located in the general vicinity of Mound Bayou, Mississippi, I would recommend that more facilities of this nature be established throughout the state.

Comprehensive health centers afford more than basic health care for people; it gives them a sense of identity and usefulness, and raises the level of dignity of each individual by the mere fact of knowing there is some place that really cares.

MRS. HATTIE MCCULLOUGH, ITTA BENA, MISS.

As one of the witnesses, everything that was reported by Mrs. Williams was truth. I live 12 miles from Greenwood in a little town called Itta Bena, Mississippi and don't get enough welfare money to get the kind of things I need to live on. The cost of living is so high, it takes all of my check to pay my bill. Very little left. My house is falling down, and almost out of doors and no way to get help to have a decent place to live. Yes I been trying to get my Social Secu-

rity. I have 5 on and they say I need two more and they won't let me and no one else pay it for me and I have bad eyes and am not able to see well enough to do anything. My age is 74. Born June the 16, 1896. Security no. is 427-60-4056.

MRS. LOUISE POINTER, GREENWOOD, MISS.

I am very much in need of a raise in income as well as dental care. So the poison may not spread all over my body. May be the OEO would help if I knew how to get in touch with them. I could also use some eye glasses.

MRS. PASTY PRATT, EUROPA, MISS.

Thank God for people like you and everyone involved in helping people who need it. There are so many people who are not able to do things for themselves like me and so I just praise you and your work to the highest, it's such good help. Thank God.

Mrs. Sadie Ford helps me and I am so pleased she has been so much help to me because I can't walk. She really looks after me and my needs. If it's any way for you to keep this organization going, we would appreciate it. Thank You.

SURLOMA RAMSEY, GREENWOOD, MISS.

I am writing to you for some help. We don't get but one check. My husband gets $73 and I don't get no help at all. After bills are paid out of that one check—gas bill, water bill, grocery bill,—$17, and our burial insurance and if we was able to buy those stamps they would cost us $32 a month. That's why we isn't able to buy those stamps and we both are sick and don't have a job and if we had one, we may not could hold it. I am not getting my pension at all. We own our own home and no income. Please will you consider this letter.

MRS. CORTIA THACKER, JACKSON, MISS.

The aged Americans are my utmost concern, because I shall ultimately reach that height. When I become aged, I'd like those years to be happy years, and not to be left out and made to feel unwanted. If I could have something to be proud of, I'd like a program for the aged. Our aged people need more good and wholesome programs such as ARTS and CRAFTS and other SPECIAL PROJECTS. Activities could include leathercraft, wood and papercraft, sewing, knitting, embroidery, toymaking, jewelmaking—gardening (flowers, vegetables); painting, drawing, etc.

Debate classes could be held to discuss issues of their choice, a study of civics with emphasis on local politics and voting would prove knowledgeable. A physical awareness of science or their immediate surroundings, quiet recreational games as cards, checkers garnished with a dab of MUSIC APPRECIATION can be very enjoyable for our older Americans.

These are just a few of the things the aged could enjoy together. To secure their views, I think a nation-wide survey should be made. If I could have but one wish, I would wish for a PERMANENT PROGRAM FOR OUR AGED AMERICANS.

MRS. M. J. WHITE, SCHLATER, MISS.

Sir, I am 71 years old and have never received any relief any more than commodity when they were issuing it to the people. And when I became 65 years old I applied for old age assistance and was rejected because I was assigned to my husband's Social Security and his check wasn't but $66. After my husband went to the hospital the welfare sent for me to meet them at Leflore County Department of Welfare in Greenwood, Mississippi. And after going to see them, they refused to help me and me and my husband is trying to make it on our Social Security. Our expenses is very high. My check is $31 and my husband's check is $33 a month.

○