

PARTICIPATION, POWER, AND PLACE:
Roots of the Community Health Center Movement

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ABSTRACT

The Tufts-Delta Health Center, established in the Mississippi Delta in 1965, was the forerunner of a movement that changed the way we think about health and health care. It furthered national awareness of the failure of traditional health systems to reach marginalized populations, and showed the effectiveness of bridging public health and clinical interventions at a grassroots level. It demonstrated why race, class, and power are important determinants of health, and why community is a critical locus for health care delivery and social change. The project not only managed to initiate an empowerment-based and comprehensive approach to health care, but it did so in the context of some of the most entrenched race, class, and status segregation in the country. Through analysis of the stories and archives of health and civil rights pioneers, this thesis examines the participatory approach they took to promoting health and community empowerment at one of the nation's first health centers in Mound Bayou, Mississippi. I use an empowerment domains framework in order to understand the application of this participatory model, sources and impacts of opposition to the center, and the ways in which these dynamics can inform contemporary health equity and reform efforts.

TABLE OF CONTENTS

Preface.....	p.1
Introduction.....	p.9
Chapter I: Health Care for the Poor.....	p.12
The Hospital and Organized Medicine.....	p.14
The Flexner Report.....	p.15
Charity and Inequality	p.17
Medicine and Public Health.....	p.18
Social Insurance.....	p.20
Post-World War II: Expansion	p.22
Post-World War II: Barriers.....	p.24
Pressure for Reform.....	p.25
Chapter II: The War on Poverty.....	p.29
New Understandings of Poverty	p.29
Lyndon B. Johnson.....	p.30
Civil Rights Linkages.....	p.31
Community Action Program and ‘Maximum Feasible Participation’	p.33
Health Care and the OEO.....	p.35
Freedom Summer.....	p.36
Awareness and Activism.....	p.39
Inspiration.....	p.40
Search for Support.....	p.43
Chapter III: Community Participation and Empowerment in Mound Bayou.....	p.46
Community Participation.....	p.47
Domain 1: Participation and Local Leadership.....	p.53
Domain 2: Problem Definition and Evaluation	p.62
Domain 3: Resource Mobilization.....	p.67
Chapter IV: Opposition to the Project.....	p.72
Opposition by the White Political and Medical Communities	p.72
Opposition by the Black Middle Class	p.76
Discussion.....	p.86
Conclusions.....	p.91
Bibliography.....	p.100

PREFACE

I first became interested in the community health center movement while organizing a symposium at Tufts University in 2007 entitled “Health Disparities & Higher Education.” The daylong event brought together hundreds of students, policymakers, researchers, and community members to explore the roles and responsibilities of academic institutions in ensuring equitable access to quality health and health care in Massachusetts. One of our morning keynote presentations was given by Elmer Freeman, a longtime community health leader in Boston and the executive director of the Center for Community Health Education, Research, and Service (CCHERS). Freeman’s presentation examined the history and legacy of community health centers in providing access to health care and many other social services for the underserved. I was struck by the relevance of this model to current efforts to reform and equalize the health care system.

Shortly after the symposium, I began interning at CCHERS and getting to know the group of fifteen health centers in Boston with which the organization partners to promote health systems change and eliminate racial and ethnic health disparities. At conferences, meetings, and rallies I had the opportunity to hear more of Freeman’s stories and meet many of his friends and colleagues involved in Boston’s health center network. I was fascinated by the idealism, the history, and the energy behind these institutions and the people who started them. One person whose stories particularly stuck with me was Bill Walczak, the founder and director of the Codman Square Community Health Center. Walczak and Freeman’s intertwining experiences over the past three decades speak to many of the concepts, complexities, and current challenges that I ultimately chose to examine in this thesis. I share some of their background here as a way

of introducing this topic in the way I first encountered it—as stories of long struggles, high hopes, and unwavering convictions that people’s needs, rather than their social or economic privileges, must guide the distribution of opportunities for well-being.

In 1972, Bill Walczak moved from New Jersey to Boston and soon met his future wife. She had grown up in a housing project on the Jewish side of Codman Square, in Dorchester, and told Bill about new housing policies the city had implemented in her community in the past decade, largely out of fear of the race riots that had followed Martin Luther King, Jr’s assassination. The city hoped that making blacks “more middle-class” by helping them purchase homes would end racial strife. In Codman Square, the geographic point where the Jewish community and the Irish Catholic communities converged, blacks were encouraged to purchase homes with federally guaranteed mortgages and virtually no money down. “The tragedy of good intentions is that that program was the cause of the Jews leaving,” said Walczak. As 80 percent of the Jewish community moved away, housing prices crashed in Dorchester and neighboring Roxbury. Houses could be sold for as little as \$1000. Many went vacant. The blacks who arrived were a much more impoverished group than the population they replaced. Quickly, the commercial districts collapsed. The whites who remained in the area were quick to scapegoat blacks for the community problems. Tensions were rising and social services were limited (Walczak interview 8/08).

By the time Bill and his wife married, moved into Codman Square, and were working at a factory in the area, “all hell was breaking loose” in the neighborhood, Walczak remembered.

“Houses were burning at a rate of one per day in the 1970s. All of it was arson.” Once busing started in 1974, the scene worsened, leading to serious conflict between blacks and whites. At the civic association meetings Walczak attended, the only topics of conversation were about who moved out, what store closed, who got mugged. People talked about issues of inequity and racial justice, but they didn’t know what to do. “There were no tools available to us,” said Walczak. One day, a panel of people came to a meeting and spoke about community health centers. They described Columbia Point, the nation’s inaugural health center set up in a large public housing project, and the other handful of centers that had opened in Boston since then. The energy in the room grew. This was exactly what Codman Square needed, they thought (Walczak interview 8/08).

Part of the reason for the civic association’s excitement about the idea reflected the location they had in mind for a future center. In 1973, the City of Boston had announced that they were going to abandon the public library in the middle of Codman Square and move it into a new location outside of the main square. “That panicked people, because that’s one of the main buildings of this community,” said Walczak. People believed that if that library closed, it would burn. Walczak was sick of hearing only about the disasters of the neighborhood. He thought, “This is something we can grab onto; this is something we can do.” At just 20 years old, he was appointed chairman of the committee to start a health center (Walczak interview 8/08).

Walczak knew nothing about health care. “What I had was a big mouth and an interest in doing something positive,” he said. His mostly white organization reached out to the other civic organizations in the community, which were mostly black organizations. They all came together in January 1975 to discuss the goal of starting a health center. It was a historic moment. About forty people attended the meeting—the first time “we’d ever pulled black and white people

together on any particular issue,” Walczak said. People were desperate for anything that would give them a sense of hope, he explained:

Good-willed people rallied around the thing that was the only game in town, which was: let’s start a health center in the old library building; let’s do something good; let’s prove this neighborhood ain’t gone.

The multiracial coalition existed for five years until the health center finally opened in the basement of the library in 1979 (Walczak interview 8/08).

The path to setting up health centers like Codman Square was neither predictable nor easy, but shaped by numerous influences, supporters, and challenges. Such were the characteristics of the personal path for Elmer Freeman, who first got involved in the community health center movement in the early 1970s. Freeman, a lifelong civil rights activist, saw poverty- and race-related struggles as a critical influence on the early centers’ development. By the 1970s, guided by the emergence of the black power movement, civil rights “was moving away from...interpersonal racism and looking more at institutional racism,” explained Freeman. The health care system was a key site of institutional racism challenged by civil rights leaders, including the Black Panthers, who organized free clinics in Boston. When the Black Panthers started to fade away, the free clinics also faded. But the interest they had aroused, including a collective focus on community participation and social determinants of health, remained. In Boston, many of the same activists who supported and staffed the free clinics began advocating and working for the community health centers (Freeman interview 11/08).

Freeman’s involvement in the community health center movement began in an effort to settle a grudge. In the early 1970s, he was working as a social worker for a city poverty agency. A pediatrician at Boston’s South End Health Center saw a patient who was the victim of child

abuse. The pediatrician insisted that Freeman file the official paperwork reporting the abuse, even though the doctor was a mandated reporter by law, and Freeman hadn't even seen the child. "I pushed back," said Freeman. "I wasn't going to do it. [But the doctor] insisted. He went to the director of the Health Center, whose wife was the director of the agency I worked at, and they made me file the 51-A." The incident—illustrating what Freeman has come to call "the tyranny of professionals"—inspired Freeman to get involved in the elections for the community board of the South End Community Health Center "with the intention of getting on and changing policy, and getting rid of this physician." Freeman served on the board for eight years, with four years as its president. "I sort of matured over those eight years," he explained. While he never managed to fire the physician (whom he now considers a close friend), he began to understand the strengths of the health center model, as well as its weaknesses (Freeman interview 10/08).

During his tenure on the board of the South End Community Health Center, Freeman worked as a health policy regulator for the state. He recalled the messy politics that nearly doomed the Codman Square Community Health Center. Many of his colleagues felt that investing in a health center in Dorchester was the wrong approach—to improve the health of the poor, public officials should be investing greater resources in Carney Hospital, the local public hospital, rather than setting up an entirely new institution, they said. Freeman knew the black immigrant population that had moved into Dorchester had little reason to choose or trust Carney. "Carney made sure you didn't feel comfortable going there," he said. Overt acts of racism were reported and circulated throughout the community. "I chose not to do battle with Carney Hospital," Freeman said. "I would rather create a health center where people feel comfortable. And maybe this health center will end up affiliating with a hospital." Freeman was right, and the

Health Center later affiliated with Boston City Hospital and Boston University Medical Center (Freeman interview 10/08).

Both Freeman and Walczak attribute much of the success of health centers like Codman Square to political advocates who fought against the conventional health care system. People like Lou Pollak, the Deputy Commissioner of Health and Hospitals at the time of Codman's founding, whom Freeman describes as the "godfather of community health centers" because of his tireless work on their behalf, helped develop new centers and integrate the public health responsibilities of the city into the centers. "Lou believed that every community should control its own healthcare," said Walczak. "You have to have some people who can stand bureaucracy and have staying power and Lou was one of those people," said Freeman (Freeman interview 10/08, Walczak interview 8/08).

Thanks to tremendous efforts from the government and at the grassroots, the Codman Square Community Health Center will soon celebrate its 30th birthday. Providing more than 125,000 individual patient visits per year, the Center currently employs 275 staff, 80 percent of whom live in Dorchester and 82 percent of whom are nonwhite. The Health Center remains committed to a community development philosophy. In addition to comprehensive primary care services, it boasts an array of community and public health services, ranging from financial literacy and college preparatory programs to HIV/AIDS services. Doctors can write prescriptions for gym memberships. The Center hosts a farmer's market. A charter school sponsored by the Center promotes intensive, six-day-a-week academic preparation and innovative health curriculum, aiming to help students become "outreach workers in their families, churches, and community groups." It has sent every single graduate to a four year college (Walczak interview 8/08).

Today, Freeman has a unique “bird’s eye view” of the dozens of community health centers in Boston. This is largely thanks to his role as Executive Director of the Center for Community Health Education, Research, and Service (CCHERS), a partnership between numerous hospitals, universities, and health centers in Boston. Much of Freeman’s and CCHERS’ work focuses on what he sees as the most important civil rights struggle of his lifetime: the elimination of racial and ethnic health disparities. This goal is central to the mission of community health centers like Codman Square whose “true to its roots,” multifaceted approach to environmental, social, and physical health is seen by Freeman as part of the answer to mitigating the disparities that burden Boston’s most vulnerable communities. “Health centers are the best kept secret...for health reform,” he says (Freeman interview 10/08).

However, Freeman worries that fewer and fewer health centers in Boston share Codman’s comprehensive, community-based model. One of them he describes as “very much a medical health center,” that does very little in terms of community health and public health interventions. In fact, the office for their community health workers is a redone janitor’s closet. This particular center is run by a large, politically and economically powerful hospital, and Freeman blames the narrow, medicalized orientation of the hospital for this approach (Freeman interview 11/08). Looking around at Codman’s peer health centers, Walczak shares this concern. “They’re medical facilities now,” he says. “Most of them have lost their interest in being true community development tools.” However, Walczak admits that due to financial issues including medical reimbursement changes and state budget shortfalls, it is understandable why so many centers have scaled back. Codman’s own economic future could be in jeopardy after one of their major subsidies disappears in 2010 (Walczak interview 8/08).

In addition, Freeman worries about whether the health center leaders are prepared to take on the next challenges. “There are still a few rebels left, like Bill [Walczak]. But for the most part, we’re older,” he says. Nevertheless, as they continue to advocate, educate, organize, and serve, Freeman and Walczak remain optimistic. With a new, progressive presidential administration entering Washington interested in health systems reform, the stage may be set for major changes that could strengthen and expand community health centers locally and nationally. Freeman hopes that future health center pioneers will be inspired by this political change and somehow find the same “built-in agitation [and] advocacy in [their] jeans” to return health centers to their roots not only as a source of quality health care for all people regardless of their ability to pay, but as a tool for profound social change (Freeman interview 11/08).

Civil rights. Politics. Participation. Medicalization. Health reform. Bill Walczak and Elmer Freeman are not your typical health care leaders, the communities with which they work are not your typical health care consumers and colleagues, and the centers they have founded and promoted are not your typical health care institutions. From where did they draw their inspiration? What role do health centers like Codman Square play today? What aspects of our nation’s peculiar approach to health care do these centers reflect, affect and challenge?

INTRODUCTION

In his 1964 State of the Union address, just seven months after assuming office, President Lyndon B. Johnson announced:

This administration, here and now, declares unconditional war on poverty in America...It will not be a short or easy struggle, no single weapon or strategy will suffice, but we shall not rest until the war is won. The richest nation on earth can afford to win it. We cannot afford to lose it (Stossel, 2004, p.333).

The cause of poverty, he added, lies:

in our failure to give our fellow citizens a fair chance to develop their own capacities—in a lack of education and training, in a lack of medical care and housing, in a lack of decent communities in which to live and bring up their children (Stossel, 2004, p.334).

Health was not originally a central part of the War on Poverty. However, shortly after launching programs like Head Start and the Job Corps, officials in the Office of Economic Opportunity (OEO), the agency which oversaw the War on Poverty, realized that participants in these programs needed health care. Many had never seen a doctor and had untreated medical problems that were not only a barrier to their own well-being, but to the broader goals of social improvement sought by OEO programs (Lefkowitz, 2007; Sardell, 1983; Hollister, 1970). A new, health-specific War on Poverty program was needed, and a young, idealistic physician named Jack Geiger advocated that a new type of community health center, modeled after one with which he had been involved in South Africa, could be replicated in the United States (Geiger interview 10/08).

For Geiger and his colleagues, vision soon became reality. The first two community health centers in the U.S., established in urban Boston and rural Mississippi, marked a convergence between civil rights vision, War on Poverty dollars, and community activists' belief in health as a human right. The centers blurred the boundaries between public health and primary care of individual patients by setting up extensive community-based services. Education, home improvements, sanitation, and cooperative farming were developed alongside medical treatment. The model found its strength at the grassroots, prioritizing the active voice, experience, and involvement of local residents.

In Mississippi, the case study for this thesis, the Tufts-Delta Health Center's efforts to promote the health and empowerment of the poor aroused the opposition of the Southern white medical and political power structure, as well as some local black elites. Both opponents perceived the new institution as a threat to longstanding social and economic hierarchies, and feared a loss of status and control. Their opposition exemplifies the challenges of implementing empowerment-based approaches to community health promotion.

For this thesis, I conducted extensive oral histories with some of the most involved doctors, community organizers, and patients of the Mississippi project. I met with John Hatch, the first head of the Tufts-Delta Health Center's community organization department in Chapel Hill, North Carolina. In Brooklyn, I met with Jack Geiger, the founder of the Delta and Boston health centers. Elmer Freeman, Bill Walczak, Anthony Schlaff, and Edna Smith spoke with me in Boston about their experiences with community health centers in the northeast. In Jackson, Mississippi I spoke with L.C. Dorsey, who grew up in the community surrounding the Health Center and served in numerous roles there, and three Mississippi-born physicians who practiced at the Center: Helen Barnes, Aaron Shirley, and Robert Smith. I also conducted archival research

examining the Delta Health Center collection and personal papers of John Hatch at the Wilson Library Special Collections at the University of North Carolina at Chapel Hill. Using these materials, in combination with numerous secondary sources, this thesis will analyze the Health Center's development, particularly exploring the achievements, limitations, and contemporary relevance of its community participation model.

Chapter I: Health Care for the Poor

Since the founding of the United States, poverty was largely seen as an “individual, not a social, problem” (Zarefsky, 1986, p.38). Public policy largely ignored the working or self-supporting poor, and the unemployed were compared to criminals. Many humanitarian efforts mirrored this philosophy by emphasizing only the *individual* aspects of self-improvement. During the late 19th and early 20th centuries, progressives challenged this dominant view, arguing that flaws of society, not the individual, should be blamed for poverty (Zarefsky, 1986). Roosevelt’s New Deal and Johnson’s War on Poverty drew much of their inspiration from this progressive outlook on poverty, viewing problems like illiteracy or disease as consequences of social inequities that their social programs aimed to mitigate.

Organized medicine, however, concentrated almost exclusively on individual disease, cure, and behavior. Beginning in the late 19th century, physicians rejected a focus on systemic causes or social determinants of health, and their emphasis on technological sophistication, scientific innovation, and medical specialization came to supersede community-oriented or environmental interests. Those institutions that reached out, through a mix of public health and clinical care, were seen by doctors as threatening and wasteful, and were thus dismantled. So too was social insurance, lacking adequate professional or societal support (Sardell, 1983).

The story of how mainstream medicine arrived at this juncture is notable, for health care was not always conceptualized, practiced, or accessed in this way. From as far back as 460 B.C., the earliest Western healers focused on natural observation of bodily processes, from mucus to menstruation, but had neither the interest nor ability to look for cures of diseases. Through simple observation, Hippocratic writers and early healers came to believe that the body was

made up of four types of fluids or *humours*: blood, phlegm, bile, and black bile. They believed that imbalances of these humours was what caused illness. In order to restore health, it was necessary to remove the poisons from the body through interventions like perspiration, urination, vomiting, and bleeding. These therapies, along with diet and exercise, were all meant to accelerate the body's natural healing process. In general, surgery was considered intrusive and unnatural, and prevention was always more of a priority than cure (Barry, 2005; Porter, 2004).

These principles formed the basis of medicine and healing until the mid-19th century. Thus, in a certain sense, health care for thousands of years was not particularly effective, yet it was accessible to virtually everyone. It was also rooted in a preventive, holistic framework that valued the compassion and care of a doctor or healer as much as his medical abilities or technical skills. As Geiger explained:

There was a time...when physicians and other health workers...recognized a responsibility even greater than that of the individual patient, and when some of them at least, fought as reformers and revolutionaries for change in societies that compelled large numbers of humans to go hungry, to live in slums, to sent [sic] their children off to factories and mills, to work in dangerous and inhuman environments, to suffer racial prejudice and oppression, and therefore to be sick (Geiger in Salber, 1975, p.1).

By the mid-19th century, knowledge of human anatomy and effective surgical procedures grew dramatically. "Disease began to be seen as something that invaded solid parts of the body, as an independent entity, instead of being a derangement of the blood," writes John Barry (2005, p.26). In addition, devices to measure temperature, heart rate, blood pressure, and other physical characteristics developed that improved the quality of diagnostic and curative care available to patients, but also changed the way people thought about health. Such innovations, Barry writes,

“created distance between the doctor and the patient, as well as between patient and disease; they objectified humanity” (Barry 26). Geiger notes that with these changes, professional responsibilities were lost:

Armed at last with real powers of diagnosis and treatment, physicians became the technicians of cure and palliation. “Cause” was something microbiological or biochemical, not something social (Geiger in Salber, 1975, p.1).

In order to more closely explore these professional and social dynamics and disruptions, it is instructive to first consider U.S. approaches to health care for the poor, beginning with doctors and the large, ubiquitous health care institutions where they practice.

The Hospital and Organized Medicine

Today hospitals are considered hubs of medical innovation and technical sophistication. However, prior to the 19th and 20th centuries, hospitals were primarily charitable and religious institutions that looked after poor and marginalized populations, and played a limited role in medical treatment (Starr, 1982). In the eyes of middle- and upper-class patients, who primarily received health care in the privacy and comfort of their homes, hospitals were places for the poor, homeless, and insane (Sardell, 1983). Wealthier Americans often opposed the construction of hospitals, believing that the patients the institutions attracted would promote immorality, irresponsibility, and laziness in their communities (Starr, 1982).

With rapid urbanization and greater public knowledge that some illnesses could be better treated in the hospital than in the home, people who had once protested their construction started lining up for care (Rosen in Freidson, 1963). The social demographic of hospital patients changed, and so too did the distribution of quality care. Less-wealthy ward patients were the

charge of hospital staff, while private patients were seen by the doctors of their choice (Starr, 1982). Food quality, visiting privileges, and other amenities followed this social gradient, and charity and private patients were separated by floor or hallway. Racially segregated wards were the norm in teaching hospitals that admitted blacks, even if they were able to pay for private rooms (Ludmerer, 1999). These segregated wards were often found in “locations such as unheated attics or damp basements” (Gamble, 1995, p.6).

With hospitals reorganized as technically-sophisticated professional businesses to bring in revenue and serve patients, rather than charities to bring in donations and serve the poor, health professionals were granted new authority. To mobilize around growing professional interests, the American Medical Association (AMA), founded in 1847, expanded, attracting 60 percent of the total physician-workforce in the U.S. as members by 1920. It was an exclusive club. Blacks were barred from their local medical societies and thus procedurally disqualified from the AMA until the 1960s. The AMA was also a politically powerful club. State licensing laws, medical education standards, and medical research regulations were determined under the aegis of the AMA. Through physician-controlled standardization, regulation, and reform, the AMA gained significant professional and political legitimacy (Byrd and Clayton, 2002).

The Flexner Report

One of the most significant demonstrations of professional authority and government influence occurred in medical education. The AMA, seeking to reform medical schools to keep pace with modernizing medicine, requested that the federal government form a national board to set standards for medical education. In 1904, the Council on Medical Education (CME) was formed (Byrd and Clayton, 2002). Even though the CME was composed of AMA-appointed

medical professionals without any official federal regulating authority, the CME “found itself with the power to present suggestions as if they were legally required” (Starr, 1982; Stevens, 1998, p.64).

In 1910, marking one of the most important milestones in the history of American health care, the CME released the Flexner Report. This document, named for study leader Abraham Flexner, was the result of extensive inspection and evaluation of the 155 medical schools in the United States (Byrd and Clayton, 2002). Highly scientific, research-oriented, well-equipped schools like Johns Hopkins were the report’s gold standard, but few schools came close to Hopkins’ level of quality. Words like “‘very weak,’ ‘wholly inadequate,’ ‘miserable,’ ‘dirty,’ and ‘utterly wretched’” adorned many of the report’s pages (Stevens, 1998, p.67).

The effects of Flexner were immediate. Standards soared for scientific and technological sophistication, teaching facilities, and medical training. Medical licensing requirements, state oversight, and stricter medical school admission requirements sprang into existence. Not every institution blossomed as a result. Twenty medical schools closed their doors to avoid being included in the Flexner Report, and ninety-two more merged or shut down due to the higher requirements, reduced funding, and bad publicity resulting from the report. The Flexner Report, with its roots in the AMA and CME, illustrated the “monopoly control” that the medical profession held on educational regulation (Stevens, 1998, p.68). Analyzing the report through a contemporary lens, Rosemary Stevens writes that:

Flexner spoke of medicine as a public service, but the overriding message of the report proved to be the need to develop scientific excellence in the schools. The two goals were not incompatible, but they did not always coincide (Stevens, 1998, p.70).

Prior to Flexner, multiple medical schools specializing in the training of women and blacks had opened. By 1923, only two of fourteen black medical schools in the U.S.—Meharry Medical College and Howard University—had survived. These schools would train most of the black physicians in America until the 1970s. Flexner reforms also limited women’s opportunities in medicine and reversed 19th century progress, with only one of seventeen women’s medical schools remaining open (Byrd and Clayton, 2002). Class constraints also took hold in medical school admissions, due to the high costs and strict educational requirements of the schools (Starr, 1982).

Charity and Inequality

The health care system had become the organized medical profession’s domain—a domain of middle- and upper-class white males. Lily Hoffman writes:

The impact of the Flexner Reforms was to eliminate a variety of intermediary practices and practitioners and to institutionalize a two-track system. This meant that the majority would pay for services received and the poor would be treated as charity patients by doctors volunteering their time at municipal or private hospitals (Hoffman, 1989, p.15)

Inequities in professional opportunity exacerbated disparities in access to health care. As fewer medical schools produced fewer graduates, major physician shortages developed in poor areas. In addition, urban areas attracted many more physicians than rural areas. In many cases, access to health care was a direct consequence of economic or developmental changes. For example, areas with more developed public transportation and telephone systems were likely to attract a greater number of physicians. A study by AMA President William Allen Pusey showed that “More than a third of 910 small towns that had physicians in 1914 had been abandoned by

doctors by 1925” (Starr, 1982, p.126). Ultimately, a shortage of physicians led to increased overall costs and reduced access for the poor (Hoffman, 1989).

As technological advances and specialization made hospitals “a place in which to be cured, rather than just cared for,” physicians began seeing more paying patients in an institutional setting (Perrow in Freidson, 1963, p.118). “This in turn changed the interests and status of the doctor,” writes Charles Perrow. “He had little vested interest in charity patients, and was less inclined to see the ‘real work’ of the hospital as care of indigents” (Perrow in Freidson, 1963, p.118). One voluntary hospital—whose allocation of free care to its immediate neighborhood was cut back so precipitously that the medical education program was quickly threatened by a lack of “teaching material”—responded enthusiastically in its 1930 Annual Report:

The future looks bright...The advance of medical science means new laboratories, new equipment and the higher ideal that it is just as important to create a great medical center where scientific work may be done by earnest young men as it is to have an efficient place for treating the sick (Perrow in Freidson, 1963, p.118).

Charity medicine was viewed as a practice of the past. Even as low-income and minority patients willingly or unwillingly served as practice material for young, ambitious doctors, there was nothing sophisticated or scientific about caring for the medically marginalized—nor was there a moral or professional imperative on the part of organized medicine.

Medicine and Public Health

Nowhere was the new medical ideology, professional prestige, and national perception of poverty and charity better illustrated than at the intersection of medicine and public health.

Unlike Europe, government public health agencies were slow to develop in the U.S. Shortly after the Civil War, several states began setting up health departments to focus on sanitation and living conditions. With few exceptions, American physicians objected to public health programs, particularly dispensaries. Founded in America's largest cities at the end of the 18th century, dispensaries were charitable institutions that provided free care and medicine for black, poor, and working-class residents (Byrd and Clayton, 2002).

As dispensaries expanded, numbering more than 100 in the country by 1900, a growing number of physicians voiced objections to the model and ostracized their colleagues who practiced medicine at such centers. They claimed dispensaries promoted medical "parasitism" by providing free care to undeserving people. Despite studies showing that as much as 90 percent of dispensary users could not afford care, the largest segment of the medical profession mobilized against this "wasteful" model (Sardell, 1983, p.26). Physicians launched propaganda campaigns against dispensary abuse by free-loaders, and many states instituted means-testing policies—ensuring that a person's financial circumstances fell within specific criteria—in order to avoid spillover between private practice and charity medicine. (Sardell, 1983).

During the 19th and 20th centuries, a similar pattern of objection emerged to other models of medical care that served the poor, embraced public health values, or fell outside the realm of mainstream medicine. As a result, some health care facilities purposefully sought to avoid conflict by tailoring their programs to fit the expectations and limitations of physicians. Health care provided in settlement houses illustrated this strategy. Established in urban neighborhoods at the end of the 19th century to address issues associated with migration, immigration, and industrialization, settlement houses provided a number of curative and preventative health services (Young, 1982). The settlement house approach focused on screening and prevention.

They emphasized a pragmatic public health approach that targeted specific diseases. While settlement house leaders knew the importance of addressing health concerns comprehensively and holistically, they kept their approach intentionally narrow to avoid threatening private medical practitioners. Settlement houses also tried to steer clear of broad, systemic views of sickness, in order to keep pace with the new medical model, which stressed specific diseases and specific approaches (Sardell, 1983).

Due to their limited scope, these “[u]ncoordinated attacks on specific diseases did little to advance a comprehensive formulation of the environmental and more particularly of the social relations of health and disease” (Rosen in Sardell, 1983, p.33). Moreover, despite delicate attempts to appease the mainstream medical establishment, settlement houses were ultimately brought down by the same forces that led to dispensaries’ demise. “Decimation,” write Linda Clayton and Michael Byrd, “was accomplished largely by the medical profession itself” (Byrd and Clayton, 2002, p.109). Ironically, these facilities did provide physicians with opportunities to learn and practice specialized medical skills; however, educational value was not enough to warrant their survival. With a lack of support from the government and a shift in institutional emphasis to curative and individual-oriented medicine, anything that hinted of preventive or community-oriented care fared no chance against the flow of the medical mainstream (Young, 1982).

Social Insurance

Social insurance in the United States met a fate similar to dispensaries. Germany was the first country to introduce a system of compulsory sickness insurance in 1883, followed shortly thereafter by ten of its European neighbors (Starr, 1982; Ross, 2002). In the U.S., national

political leaders took little interest in social insurance, and it was primarily “non-government reformers” like socialists and progressives who pushed for it (Starr, 1982; Ross, 2002, p.29). The American Association for Labor Legislation (AALL) drafted a proposal, eventually supported by Theodore Roosevelt’s Progressive Party, that focused on using insurance to compensate for medical costs (Ross, 2002). At first, thanks to the involvement of several of its own physicians in drafting the proposal, the AMA supported the AALL’s social insurance idea. A few states set up commissions to research social insurance and introduce insurance legislation (Oberlander et al, 2005).

However, support for health insurance quickly lost steam. Wilson’s defeat of Roosevelt in the presidential election of 1912 brought a decreased interest in social legislation. The life insurance industry felt directly threatened by the public health insurance concept, as did physicians, increasingly oriented against the idea of group practices and payment schemes aiming to better control costs (Ross, 2002). The entry of the U.S. into World War I dealt a final blow to the health insurance prospect, as opponents in the U.S. seized the opportunity to describe Germany’s social insurance as “a Prussian menace inconsistent with American values” (Starr, 1982, p.253). The AMA leadership, including those who had welcomed social insurance a few years before, officially condemned the proposition in 1920 (Numbers in Leavitt and Numbers, 1985).

After World War I, the national debate over health insurance was resurrected briefly when a small group of frustrated physicians departed from the AMA mainstream and established the Committee on the Cost of Medical Care (CCMC) in 1927. Their final report described group practice and voluntary health insurance as “the best means of solving the nation’s health care problems” (Numbers in Leavitt and Numbers, 1985, p.273). Not surprisingly, the CCMC was

unable to reach unanimity on this issue within its committee, and a minority report argued that insurance would result in “destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession” (Numbers in Leavitt and Numbers, 1985, p.273). The AMA leadership concurred.

Organized medicine’s opinions and power had lasting impact. In 1934, when President Franklin D. Roosevelt drafted legislation for the Social Security Act, many Americans thought the moment for compulsory health insurance had arrived. However, opposition and pressure from physicians in response to the AALL and CCMC recommendations led Roosevelt to omit health insurance from the Social Security bill he sent to Congress in 1935, fearing that the inclusion of insurance would have doomed the passage of the entire Social Security Act (Starr, 1982).

Post-World War II: Expansion

The post-World War II period marked major changes to the American health care system. One notable change was the number of individuals covered by private insurance after the war. Commercial insurance, initially focusing on hospital-related costs, had quickly gained traction and AMA support in the 1930s with the introduction of “Blue Cross.” By the 1940s, popular “Blue Shield” private insurance was covering medical services. The number of people covered by health insurance tripled after the war. Due to government fears of wartime salary inflation, health insurance was one of the few “fringe benefits” that unions were able to seek and companies could offer (Oberlander et al, 1985). Another factor fueling the growth of private insurance was the 15 million soldiers and millions more dependents who had been receiving high quality, accessible, free medical care from the military. With raised expectations about the care

they should receive, postwar families were eager for private insurance. Private insurance companies, in turn, were becoming increasingly popular and powerful (Starr, 1982).

Another change brought about by the war was the extent of government involvement in the health care sector. Wartime collaboration between the federal government and private universities had resulted in notable medical achievements, including the discovery and widespread use of penicillin and malaria prophylaxes. Aiming to maintain this scientific and technical momentum, several federal programs and policies took hold. These programs shifted the focus of the health system from small-scale, office-based primary care to large-scale, hospital-based medicine and research (Hoffman, 1989).

Building up the nation's weak hospital system was a major postwar priority. From 1947 to 1971, the Hill-Burton Act provided \$3.7 billion of federal funding that "virtually rebuilt America's private hospital system" (Byrd and Clayton, 2002, p.205). With money for construction and stronger links to universities, hospitals grew into major research and training enterprises (Starr, 1982). Physicians, whose "image...had turned decidedly heroic" in the postwar medical boom, sought institutional affiliation (Ludmerer, 1999, p.122). Between 1950 and 1969 the number of physicians employed and salaried by universities more than doubled (Hoffman, 1989).

Public support for this medical expansion was high. Ideologically, the expansion fit the postwar celebration of prosperity and modernization. It was seen as a source of new businesses and jobs, and a way to avoid the deleterious impact of disease on income and productivity (Ludmerer, 1999). "[M]edical innovation ...offered the prospect of improved well-being without requiring any profound reorganization of the society," writes Paul Star. It "epitomized the postwar vision of progress without conflict" (Starr, 1982, p.336).

Post-World War II: Barriers

Meanwhile, American urban centers were undergoing demographic shifts. Low-income populations from the rural United States and Caribbean migrated to mainland cities, while affluent populations from cities set off for the suburbs. As physicians joined this suburban exodus, cities were left with many newcomers and few health professionals or institutions to serve their myriad needs (Hollister, 1974). With a corresponding decline in general practice, these patients were forced to visit several different physicians at different clinics for different problems. Physicians served on a rotating and part-time basis at these clinics, and patients were rarely guaranteed that they would see the same physician twice (Sardell, 1983). As Paul Starr describes:

Gleaming palaces of modern science, replete with the most advanced specialty services, now stood next to neighborhoods that had been medically abandoned, that had no doctors for everyday needs, and where the most elementary public health and preventive care was frequently unavailable. In the 1960s many began to observe that abundance and scarcity in medicine were side by side (Starr, 1982, p.363).

Thus, as postwar healthcare infrastructure exploded, redistribution was neither a federal priority nor an on-the-ground reality for the vast numbers of people becoming increasingly isolated from health services.

Desperate for alternative sources of care, poor urban residents visited hospital emergency rooms, oftentimes for non-emergent medical conditions (Sardell, 1983). Flagrant disparities existed within the hospital environment. Even outside the South, private urban hospitals excluded and discriminated against black physicians and patients alike. In 1954, two out of

Chicago's seventy-six hospitals accounted for 60 percent of all black births in the city (Barton Smith, March 2005). In many cases, poor and non-white patients at public hospitals continued to be seen as "training material" for medical schools and research institutions (Byrd and Clayton, 2002, p.206).

This racism was further aggravated by the Hill-Burton Act's "separate but equal" doctrine that protected, promoted, and perpetuated institutional segregation. The Act allowed local authorities full discretion over the use of the federal funds for building and expanding hospitals, and supporters of racially exclusionary facilities spent their dollars accordingly. Under Hill-Burton, communities had to prove their financial viability by raising two-thirds of their hospital's costs, thus disqualifying many of them from receiving federal funds (Byrd and Clayton, 2002). A later concession in the Act required that hospitals receiving Hill-Burton funds make available "a reasonable volume of hospital services to persons unable to pay." But what "a reasonable volume" might be went unspecified, and the requirement was never enforced (Starr, 1982, p.350).

Pressure for Reform

However, concern for the health needs of the poor was not completely ignored in the national political arena. In his State of the Union address in 1945, President Truman argued that "the health of American children, like their education, should be recognized as a definite public responsibility" (Truman, 1945, para. 58). Truman was well aware that compulsory health insurance had "stood on the periphery of national politics throughout the New Deal – omitted from Social Security, never fully backed by the president, subordinated to other programs" (Starr, 1982, p.280). He was ready to give it another shot. Truman proposed a major overhaul of

the nation's health care system through legislation and funding that would address the shortage of health professionals and low quality of hospitals in rural and low-income areas. The most controversial component of the plan was a proposed national health insurance plan, to be run by the federal government (Starr, 1982).

When Truman's proposal was brought before Congress in the form of a Social Security expansion bill, it was immediately attacked by organized medicine. The AMA launched a massive publicity campaign against the bill. Taking advantage of Communist hysteria, the AMA labeled the bill "socialized medicine" and its writers "followers of the Moscow Party line" (Truman Library & Museum, n.d., para. 4). The propaganda was effective. Instead of national health insurance for all Americans, the U.S. would evolve to have a two-tiered system: "private insurance for those who could afford it, and public welfare services for the poor" (Starr, 1982, p.286).

From hospitals and dispensaries to Flexner and social insurance, concern for the health needs of the poor found little compatibility with American individualism. Outside of the United States, countries developed very different policies and programs rooted in the concept of "social medicine," an ideology based on the following principles:

1. Social and economic conditions profoundly impact health, disease, and the practice of medicine.
2. The health of the population is a matter of social concern.
3. Society should promote health through both individual and social means

(Anderson et al, 2005, para. 3).

While the words look nearly identical, social medicine and socialized medicine were very different ideas, with *socialized* medicine "referring to [medicine's] identity with government"

and *social* medicine “indicating a wholesome and productive partnership between the two covering disciplines of sociology and medical practice” (Bluestone in Sidel, 2006, p.2). A key facet of social medicine is understanding not only the biological and behavioral risk factors for a condition like obesity (e.g. poor diet), but the “causes of these causes,” the political, material, and psychosocial conditions that affect disease risk (e.g. food access and affordability, nutritional education, corporate marketing, and cultural preferences) (Marmot in Marmot and Wilkinson, 2006, p.2). Taken together, these circumstances are often referred to as “social determinants of health.”

The 19th century work of German physician Rudolf Virchow was particularly groundbreaking the global development of social medicine. While investigating a typhus outbreak, he argued that economic insecurity and political disenfranchisement played a major role in the epidemic. Other European countries analyzed statistical data throughout the 19th and 20th centuries to show the correlations between health and wealth. In Latin America, Salvador Allende and Che Guevara became major advocates for social medicine in the mid-to-late 20th century, arguing extensively for broad interventions to address the social and political origins of ill health beyond that of medicine’s typical purview. In South Africa in the 1930s, Sidney and Emily Kark developed a model of community oriented primary care based on the same principles (Anderson et al, 2005).

The U.S. failed not only to embrace this comprehensive social medicine model, but also to deliver essential primary health care to many populations. However, the increasingly visible inequities of postwar health care funding and delivery “generated pressure for federal intervention” (Byrd and Clayton, 2002, p.216). The 1950s and 60s saw numerous commissions, reports, and court cases documenting segregation and discrimination in the health care system.

Eisenhower's National Health Interview Survey revealed racial disparities in health care that had never before been formally measured, and Truman's executive orders "ending discrimination in federal employment and segregation in the armed services" led to the integration of all VA hospitals (Barton Smith, Aug. 2005, p.4; Barton Smith, March 2005, p.318). However, even after the Brown vs. Board of Education decision of 1954, ending *de jure* segregation in the United States, the majority of U.S. hospitals and medical institutions remained racially exclusionary. Thanks to pressure from black physician-activists and civil rights lawyers, Title VI was included in the Civil Rights Act of 1964 under President Johnson, prohibiting "the provision of federal funds to organizations or programs that engaged in racial segregation or other forms of discrimination" (Barton Smith, Aug 2005). The implementation of Medicare in 1965 brought Title VI to the next level by integrating hospital examination and waiting rooms, medical staffs, and even blood supplies (Barton Smith, March 2005). The same Congress that passed the Civil Rights Act, Title VI, and Medicare would support other opportunities for progressive change during the 1960s, including the War on Poverty.

Chapter II: The War on Poverty

New Understandings of Poverty

Out of the national shock and sadness following President John F. Kennedy's assassination in 1963 emerged new opportunities for combating poverty and improving community health—goals Kennedy himself had barely accomplished. Shortly after his inauguration, President Kennedy requested that his brother, Attorney General Robert Kennedy, set up a program in the Justice Department aimed at addressing juvenile delinquency. The program was advised by Columbia University professor Lloyd Ohlin, who studied urban gangs and delinquency. Ohlin believed that juvenile delinquency was not a result of individual failure, but a consequence of one's social environment. Reversing this pattern required working directly with the communities in which these young people lived. Applying Ohlin's innovative approach more generally to communities affected by poverty ignited the interest and support of Robert Kennedy. He came to believe that the poor should be able to determine how the government spent its anti-poverty dollars (Stossel, 2004).

At the same time, Michael Harrington's 1962 publication of *The Other America* aroused the curiosity and concern of President Kennedy. Harrington reviewed extensive U.S. economic data to conclude that up to one-third of the American population lived in poverty. Harrington was one of the first scholars to describe poverty as a "separate culture, another nation, with its own way of life" that persisted from generation to generation (Stossel, 2004, p.336). Like Ohlin, Harrington's influential book and articles argued that much more than money and jobs were needed to fight poverty; there needed to be a "vast social movement; a new period of political creativity" (Zarefsky, 1986, p.25). In the weeks and months after reading *The Other America*,

Kennedy became actively committed to the issue. Research reports, committees, and meetings focused on how to make poverty a key aspect of his 1964 reelection campaign. Just weeks before his assassination, Kennedy told his close colleagues that he hoped to soon unveil “a national assault on the causes of poverty, a comprehensive program, across the board” (Stossel, 2004, p.340).

Lyndon B. Johnson

While Kennedy had provided much of the inspiration for the War on Poverty, his successor, Lyndon B. Johnson, was stirred by similar instincts. Johnson had not grown up in poverty, but had seen much of it during his childhood in Texas and his experiences teaching impoverished Mexicans in his home state. His first government post, which involved directing a statewide New Deal program aimed at providing jobs for young people, made Johnson idolize President Franklin Roosevelt. As Roosevelt had demonstrated with the New Deal, poverty alleviation was a “do good” issue that made for an outstanding political legacy (Dallek, 2005). Adopting Kennedy’s poverty focus would memorialize the late president, while engendering a sense of political continuity and stability. Under a Democratic Congress elected in 1964, funds and support for special projects suddenly became available that had not been available under Kennedy’s Republican-controlled Congress (Sidel interview 8/08).

Johnson was also a strong civil rights supporter during his presidency. Prior to the announcement of the War on Poverty, he had pushed hard for the successful appointment of African Americans to important government positions, including the promotion of Carl Rowan as the first black director of the U.S. Information Agency. He also prohibited his administration from attending or speaking at segregated meetings or events, including an order that NASA

administrator James Webb cancel a speech to a group that closed its doors to blacks (Holliman 10/16/96). Just a month after announcing the War on Poverty, but before the antipoverty legislation was passed, Johnson accomplished one of the greatest victories of his political career: signing the Civil Rights Act of 1964 into law. With passage of this landmark legislation, racial segregation was officially illegal (Dallek, 2005).

When it came to the intersection of poverty and race, Johnson's positions were less clear-cut. Poverty afflicted the nation's African American communities. In 1964, while "78 percent of all poor families were white, nearly half the nation's black population was poor" (Zarefsky, 1986, p.42). In urban slums, where the highest concentration of poverty existed, the majority of residents were black. Despite this, the Johnson administration's framing of the War on Poverty carefully avoided framing it as a "help-the-blacks program" (Yarmolinsky in Hamilton and Hamilton 1997, p.157). White, rural poverty remained the face of the War on Poverty, as reflected in the program literature and regions included in Johnson's "tour of poverty" in 1964. Disliking welfare programs but believing that racial problems in the U.S. were inherently *economic* problems, Johnson hoped that providing jobs and better income to minorities would earn them greater respect by whites (Zarefsky, 1986). Thus, Johnson was hesitant to acknowledge the extent to which blacks lacked economic parity with whites due to hundreds of years of socioeconomic inequalities. However, he was comfortable suggesting that the War on Poverty would solve racial problems due to new opportunities for individual self-help.

Civil Rights Linkages

As he worked to design and promote his antipoverty initiative, Johnson concluded that it was important to make a strong linkage between the civil rights movement and the War on

Poverty linkage in order “to assure blacks that the poverty program was not a cover for abandoning the commitment to civil rights” (Zarefsky, 1986, p.43). This frame had other benefits, as well. Eager to quiet the tumult in the South, Johnson saw the War on Poverty as a way to use the civil rights movement’s energies towards his quieter, do-good agenda. Civil rights leaders saw advantages to this linkage, too. They knew that social reform was critical to achieving the movement’s goals of opportunity and equality, and a new national focus on poverty would raise public support for their agenda (Zarefsky, 1986).

After Sargent Shriver—President Kennedy’s brother-in-law, former Peace Corps director, and future director of the Office of Economic Opportunity (OEO)—assured a group of integration supporters that “the struggles against poverty and for civil rights ‘are all part of the same battle,’” Martin Luther King, Jr. and the Southern Christian Leadership Conference (SCLC) responded with praise for the President’s efforts (Zarefsky, 1986, p.43; Kotz, 2005). In his book, *Why Can’t We Wait*, King wrote:

Today, the dimensions of Johnson’s leadership have spread from a region to a nation. His recent expressions, public and private, indicate to me that he has a comprehensive grasp of contemporary problems. He has seen that poverty and unemployment are grave and growing catastrophes, and he is aware that those caught most fiercely in the grip of this economic holocaust are Negroes. Therefore, he has set the twin goal of a battle against discrimination within the war against poverty (King, 1964 in Kotz, 2005, p.97).

While they commended Johnson and adopted his agenda, the SCLC refused to accede to his requests that they end their civil rights demonstrations. When King announced a massive voter registration campaign in the South, designed to demonstrate the critical need for federal legislation to protect voting rights, Johnson tried to dissuade him. He assured King that such

legislation to protect black voting rights would come eventually. Johnson urged him to focus the civil rights movement on garnering support for the War on Poverty, instead. “I think in the long run [the War on Poverty will] help Negroes more, as much as a voting bill,” argued Johnson (Kotz, 2005, p.244). Well aware that the “the political action was in the White House and in the Congress, an arena in which the SCLC barely had a presence,” King and the SCLC would not back down on its political agenda (Kotz, 2005, p.97). King responded, “Political reform is as necessary as anything if we’re going to solve all these other problems” (Kotz, 2005, p. 244).

Voting rights efforts gained momentum. The President’s War on Poverty agenda pressed forward. Johnson worked tirelessly to lobby for his program, telephoning business leaders, Republicans, and labor unions to solicit their support. “He felt that if he was able to build enormous support for fighting poverty, then that wouldn’t seem something that was liberal and off on the left” said presidential historian Michael Beschloss (Holliman 10/18/96). In September 1965 Johnson signed into law the resulting legislation, known as the Economic Opportunity Act, and set up the OEO, under Shriver’s leadership, to coordinate the War on Poverty programs (Holliman 10/18/96).

Community Action Program and ‘Maximum Feasible Participation’

The War on Poverty legislation was divided into seven titles, each with unique goals and target populations. Title I, for example, mostly included youth programs like the Job Corps, and Title V focused on employment and training opportunities (Ashmore, 2008). The Community Action Program (CAP), Title II, was the central feature of the Economic Opportunity Act, and received half of the total OEO funds (Alcock, 2005). CAP was also one of the most controversial, in part because it bypassed local and state governments by administering funds

directly to OEO projects or channeling them through non-governmental organizations, academic institutions, and community groups. This arrangement aimed to evade segregationist local governments and “protect the rights of poor minorities” (Ashmore, 2008, p.29). Even a governor’s veto of an OEO proposal could be overridden by the federal government (Hamilton and Hamilton, 1997, p.158). Unsurprisingly, it evoked resentment and resistance among many mayors and governors, particularly in the South (Lefkowitz, 2007).

Another reason for controversy over CAP was the requirement that projects be “developed, conducted, and administered with the *maximum feasible participation* of residents of the areas and members of the group served” (emphasis added) (Alcock, 2005, p.323). It is unclear where the phrase “maximum feasible participation” originated, however, it seems to have grown out of a belief in the importance of the poor acting as “their own agents in mitigating poverty” (Ashmore, 2008, p.30). The concept was vague, with nothing in the legislation specifying what participation even meant or how it was evaluated (Zarefsky, 1986). Nevertheless, the maximum feasible participation requirement allowed the federal government an opportunity to intervene where various “preconditions of the legislation were not being met,” and the phrase was cited frequently in program literature, grant applications, and progress reports (Ashmore, 2008, p.30).

Civil rights groups became involved in OEO programs and, “[t]hrough congressional testimony, speeches, conferences, and correspondence,” gave input on how the programs should be designed and run (Hamilton and Hamilton, 1997, p.158). As authors Dona Cooper Hamilton and Charles V. Hamilton point out, the late 1960s was a time of increasing turbulence. The Black Panthers and other civil rights groups emerged, frustrated by and eager to challenge the approaches and ideologies of established civil rights leaders. With instability exacerbated by

inter-group tensions and the assassinations of President Kennedy, Martin Luther King, Jr., and Robert Kennedy, the War on Poverty programs offered a stable move forward (p.158-9). “Civil rights groups surely differed in style, tactics, organizational structure, and even constituency bases,” write Hamilton and Hamilton, “but their views were quite compatible with regard to the ‘war on poverty’ programs” (p.164). Group leaders supported the idea of the government taking a larger role in social welfare and anti-poverty programs, particularly in light of the community leadership and job creation goals common among OEO-backed initiatives (p.160).

Health Care and the OEO

Health was not originally a central part of these anti-poverty programs (Young, 1982). However, shortly after launching programs like Head Start and the Job Corps, OEO agency officials realized that participants in these programs desperately needed medical care. Count Gibson, a physician from Tufts Medical School who co-directed the first health center, explained:

through the Job Corps and Neighborhood Youth Corps they found young men whose teeth were all gone already at 18, who had unrepaired hernias and a whole variety of other lesions. . . . They found themselves laying out large sums of money to pay the private sector for the repair of these things in a catchup [sic] kind of way (Gibson in May et al, 1980, p.585).

Many participants had never seen a doctor and had serious untreated health problems that were not only a barrier to their own well-being, but to the broader goals of social improvement sought by OEO programs (Lefkowitz, 2007; Sardell, 1983; Hollister, 1974).

To fill this gap, local agencies requested federal funding to purchase medical services from the private sector. However, this intervention was inadequate. Ms. Lee Bamberger Schorr, who was responsible for developing initial demonstration programs, recalled:

we very quickly decided that if OEO was going to spend any substantial amounts of money on health, it would have to be directed to changing the organizational framework through which health services were being delivered to poor people (Schorr in May et al, 1980, p.585).

Health services delivered to the poor required more than just dollars – they required fundamental changes to the way care was organized and delivered (Schorr and English in Hollister, 1974).

A new health-specific War on Poverty program could be the perfect cost-saving setting for innovation and experimentation in health service, OEO officials agreed. They asked the Department of Health, Education, and Welfare (HEW) and other institutions for proposals to provide health services (Sardell, 1983; Lefkowitz, 2007). The responses the OEO received were very fragmented. Most addressed specific health problems, like hearing or vision, or focused on limited aspects of health care, like screening and vaccination. Critics were quick to point out that a few new loophole programs wouldn't make a big difference. People needed holistic, quality care (Levitan in Hollister, 1974). A young physician and civil rights worker named Jack Geiger would soon propose a comprehensive solution.

Freedom Summer

In 1964, Freedom Summer brought hundreds of student volunteers to Mississippi to join the civil rights projects throughout the state. Most of the volunteers recruited by the Student

Nonviolent Coordinating Committee (SNCC) were Northern white students whom SNCC put to work helping Mississippi blacks register to vote (Kotz, 2005). At that time, fewer than 5 percent of adult black citizens in Mississippi were on the voting rolls. In addition to voter registration, SNCC had other goals in mind. They hoped to draw these students “directly into the battle for racial democracy in the South and give them, their families, and communities—and hopefully the nation—a greater stake in the outcome” (Ransby, 2003, p.321). Black Southerners had always resisted violence and racism, collectively and individually, with little outrage from whites. Freedom Summer would alter that dynamic, placing whites into the turbulent front lines of civil rights activism. SNCC leader Ella Baker saw Freedom Summer as a transformative moment for the student volunteers. In a column in *The Southern Patriot*, she explained: “We wanted their coming to mean something creative for each of them personally as well as for the movement” (p. 325).

Fresh out of medical residency training, Jack Geiger was a field coordinator in Mississippi in 1964, working with a group of doctors and nurses to provide emergency medical care for civil rights workers who were active in the voter registration campaigns (Lefkowitz, 2007; Wright, 2005). Geiger had originally gone to medical school at Case Western Reserve Medical School hoping to do nucleic acid research but, after breaking much of his lab equipment, realized that he wasn’t cut out for laboratory research. He wondered how to put his career and life, which had been involved since adolescence in the civil rights movement, together.

I was standing on the steps of the medical school one day beyond which you could see the teaching hospital, beyond which you could see the city of Cleveland. And it occurred to me that in Cleveland, who got sick, and who didn’t, and what happened to them and

their interactions with the health care system and why they got sick were not just biological phenomena; they were social phenomena. I thought I'd invented social medicine (Geiger interview 10/08).

After running to the library, he was humbled to discover that “the British and the Germans had already done it about 150 years ago.” Nonetheless, Geiger still felt dissatisfied with the way American physicians and scholars approached the field. “The American literature at the time was dreadful,” he said. “It was all fluffy talk about the whole person and it wasn't social medicine, it wasn't anything you did, it was just an attitude you had” (Geiger interview 10/08).

Eager to translate his own attitudes into practice, Geiger prepared for a career in international health, which included spending part of his fourth year of medical school studying and practicing medicine at health centers in South Africa (Wright, 2005). Just weeks after finishing his training, he flew to Mississippi with the Medical Committee for Civil Rights – later the Medical Committee for Human Rights (MCHR). Founded in close partnership with SNCC and other peer civil rights groups following the brutal murders of Freedom Summer volunteers Michael Schwerner, Andrew Goodman, and James Chaney, MCHR helped ensure the safety and well-being of civil rights activists during demonstrations. Over the course of the 1964 summer, ninety-eight MCHR-affiliated doctors, nurses, social workers, and administrative support staff “attended to, in one way or another, the thirty-five arsons or bombings, eighty beatings, one thousand arrests and six murders of Mississippi's Freedom Summer ” (McCray, 2007, p.26).

Care was geared not just “for the kids coming from the outside,” Geiger explained, “but also for the indigenous civil rights workers, the young people of color in Mississippi who were the backbone of the movement then” (Geiger keynote, 2005). While MCHR's initial goal was to provide medical care to civil rights activists, the organization took up many other health and

social justice issues. In the late 1960s, MCHR would grow to over 6,000 members fighting to integrate hospitals and medical societies, and combat various inequities, injustices, and inefficiencies of the health care system. It called itself the “voice of humanistic medicine” in opposition to the AMA’s slogan, the “voice of American medicine” (Rogers, 2001, p.7).

Awareness and Activism

Ella Baker’s predictions had proved accurate—it was a humbling, formative time for these young activists and professionals. As physician and MCHR activist Fitzhugh Mullen recalled, the volunteers who traveled to Mississippi were shocked by the racial, economic, and health disparities they witnessed in rural Delta communities. With new awareness came many questions: “Why did black babies die at twice the rate of white ones? Why did whites in Mississippi live on average ten years longer than blacks? Why were hospitals segregated?” (Mullen, 2006, p.11).

With questions came anger and action. For the medical professionals who participated in the MCHR and larger Freedom Movement, experiences in the South transformed their personal and professional understandings of the world. Mullen realized that the deprivation faced by blacks “was caused by the system and not the people. The Mississippi system foreordained [their] poverty.” He realized that overcoming this poverty required fundamental, systemic changes. Mullen also discovered a new purpose and passion for himself as a physician. “In [Mississippi], in the Civil Rights Movement,” he wrote, “I experienced a cause and felt a love that helped medicine make sense to me” (Mullen, 2006, p.19).

Like his MCHR colleague Mullen, Geiger was stirred by the poverty he saw in Mississippi. His dreams and years of preparation for a career in international health suddenly shifted as he discovered a new, more local calling:

That summer it became clear to me that I didn't have to go to Africa or Latin America or Southeast Asia. We have a third world here in the United States, in the rural South, in the ghettos of the inner city, in Appalachia, on the Indian reservations, in the health status of all those populations – not at the same absolute level, but certainly at the same relative level of deprivation. There was a task for us here at home... (Geiger keynote, 2005)

At the end of Freedom Summer, Geiger and his MCHR colleague Count Gibson raised money from wealthy Northern friends to start a small clinic in Holmes County, Mississippi, called the Milesdon Clinic. They recruited doctors and nurses from UCLA. "It was effectively a tiny operation," Geiger remembered. "It was just clinical care, that's all it could be. It was desperately needed" (Geiger interview 10/08).

Inspiration

The poverty and inequity Geiger saw in the South reminded him of what he had observed in the developing world. During his fourth year at Case Western Medical School, Geiger had worked in South Africa at Pholela Health Center, which primarily served an impoverished local Zulu population in what is now Kwazulu-Natal. The Center was established by physicians Sidney and Emily Kark, who were recruited to South Africa in 1940 by the Secretary of Health of the Governmental Health Department (Goffin, 2006). Pholela was based on a model of community-oriented primary care (COPC), which aimed to connect community development and primary health care. The model focused broadly on health, emphasizing the social, economic,

and environmental factors that determine population health status. Community organization and involvement was at the crux of the Kark's approach, and local residents were equipped with the skills and resources to deliver intensive health education and environmental improvements. COPC emphasized the collection and use of empirical evidence as a basis for policy and program development (Geiger, 2002; Yach and Tollman, 1993; Lefkowitz, 2007). While the Karks planned to establish over 200 health centers in South Africa modeled after Pholela, the introduction of restrictive apartheid policy ultimately brought development to a standstill and forced the existing centers to close. Sidney Kark became founding chairman of the Department of Epidemiology in the School of Public Health at the University of North Carolina in Chapel Hill in 1960, then moved with Emily to Jerusalem where they continued to spread the COPC approach to students and health institutions globally (Goffin, 2006). Throughout their time in South Africa, the United States, and Israel, the Karks strongly inspired and advised Geiger's work.

In December 1964, after Freedom Summer, Geiger and his MDHR and civil rights colleagues gathered in Greenville, Mississippi. The meeting was also attended by leaders of Student Nonviolent Coordinating Committee, the Southern Christian Leadership Conference, and the Congress of Racial Equality to plan how to maintain the momentum from previous summer and find new direction (Geiger, 2005). It was a kind of floundering time," said Geiger (Geiger interview 10/08). The group agreed that it was time to focus on local problems, specifically the lack of basic services in poor communities (Lefkowitz, 2007).

The extent and impact of local poverty was constantly on Geiger's mind as he returned to Mississippi in the fall of 1964 to keep the Milesdon clinic running. He knew the importance of the services the clinic offered. At the same time, though, he felt "a real sense of kind of letdown

after the summer,” realizing how little the voter registration campaigns had improved the day-to-day life of Mississippi blacks, and how inadequate even the clinic was in permanently fixing the health problems of the poor (Geiger interview 10/08). Robert Smith, a native Mississippian physician and MCHR member, was also at the Greenville meeting and spoke to the group about his experiences practicing medicine at the Milesdon clinic. “I’d write someone a prescription and the next week his prescription was [still] right there,” he said. “I had never been trained to take care of all these social problems... We needed a different type of delivery system” (R. Smith interview 12/08). Geiger and Smith saw firsthand how much the “downstream” medical problems afflicting Southern minorities were a direct consequence of the “upstream” poverty, oppression, and other structural inequities that medicine alone was unable to cure.

This downstream/upstream metaphor extended to many other issues and programs, including education. One of the primary topics of conversation at the Greenville meeting was the struggle over Operation Head Start, one of the first War on Poverty programs. Founded by MCHR volunteer Tom Levin, Mississippi’s Head Start program provided early education, medical care, and hot meals to preschoolers and decent jobs to local people. It was labeled a “model program” by OEO (Dittmer, 1995, p.369). Levin, like his MCHR colleagues, saw the program as “much more than simply early childhood education.” It was, he explained, “a focus to organize a community around all their social aspirations” (p.369).

Levin’s passion for education and social justice was matched by passionate objection and outrage by Mississippi’s white establishment. Local newspapers compared Head Start to programs in “Soviet Russia...Red China...[and] Hitler’s Germany” and Ku Klux Klan members fired bullets into Head Start centers (Dittmer, 1995, p.370-371). The opposition was not directed specifically to Head Start as a program, per se, but to the entire War on Poverty concept which

they saw as “an enormous threat to the established system” since the federal government was giving “money and control *directly* to minority populations, rather than through the gatekeepers” (Geiger interview 10/08).

Despite these struggles, the conversation about the impact of Head Start and the overarching need for local services gave Geiger an idea. He proposed a health center based on community oriented primary care principles that would not only spur improved health outcomes, but would also provide a vehicle for community organizing in pursuit of other civil rights and poverty-alleviation goals. He described the Kark’s model, and argued that a Northern medical school, far-removed from the local opposition to helping blacks, should support a COPC program in Mississippi. His colleagues supported the idea, and Gibson, Geiger’s MCHR colleague from Tufts Medical School, suggested that Tufts could be the Northern academic sponsor they were looking for (Wright, 2005; Sardell, 1983; Lefkowitz, 2007).

Search for Support

Over the next three weeks, Geiger met with the Dean of Tufts Medical School, and the Vice-Chancellor and President of the University. He recalled their response:

Fifteen-hundred miles away, a health center in Mississippi, this whole crazy thing sounds great, it’s what a university should do, we’ll guarantee your salary for two years, go do it (Geiger and Bellin, 1966, p.4).

While the Board of Trustees at Tufts had some reservations about the project, they approved the project because the grant provided the school “with a sense of mission” as it struggled to compete with the stronger endowments and reputations of peers like Harvard (May et al, 1980, p.591). In return, Tufts’ support was crucial to the OEO’s eventual acceptance of the community

health center grant. “A key factor in overcoming Shriver’s anxiety...was that there was a major, quality medical school that they were giving this to,” said Geiger. “I don’t think that it would have gotten started in any other way.” Gibson added, “[Tufts] was indispensable. There would have been no way to have started without going through the University” (Geiger and Gibson in May et al, 1980, p.589).

With civil rights inspiration from Mississippi, institutional support from Boston, and federal interest from Washington, Geiger and Gibson outlined a plan. They based their completed proposal on the premise:

...that the existing system of charity care, emergency departments, fragmented outpatient departments, and separate public health clinics and programs, north and south alike, had failed adequately to serve the primary care needs of the nation’s poor and sick populations—especially communities of color—and that a new kind of institution, located in such communities and directly responsive to their needs, was required (Geiger, 2005, p.314).

The proposal did not indicate the specific location of the Southern center. This was partly due to Geiger and Gibson’s own uncertainty, having explored data from eight states. Geiger saw Mississippi as the most politically feasible location. “I knew if we went to Georgia people would think of Atlanta and think it was better than it really was,” he said, “but if we went to Mississippi, people would assume it was worse than it really was” (Geiger interview 10/08). Another critical reason for the grant’s geographic ambiguity was to avoid having to clear the location with any Southern delegation in Congress, which would undoubtedly attempt to stop the project. In addition to the unspecified Southern site, Geiger and Gibson decide to request funding

for a center in Boston, closer to the home of their Tufts institutional sponsor, in their proposal (Lefkowitz, 2007).

The model they described in their OEO proposal was comprehensive, with a broad focus on the physical, social, economic, and environmental determinants of health (Lefkowitz, 2007). It was committed to the participation of community residents—a winning characteristic in the eyes of OEO leaders, whose mission stressed “maximum feasible participation,” and one whose emphasis on empowerment and equality resonated with leaders of the larger civil rights movement (Geiger, 2002, p.1714). On June 11, 1965, the OEO approved the proposal for the establishment of two centers, marking the first OEO grant awarded for a health care delivery project. Geiger and Gibson had originally asked for \$30,000. Within a few weeks of expansive planning, the budget for the two centers grew to \$1.3 million (Lefkowitz, 2007).

Chapter III: Community Participation and Empowerment in Mound Bayou

The Tufts-Delta Health Center project was rooted in a community participation model that approached health intervention from an empowerment framework. This approach allowed relatively powerless people to gain control over decision-making and resources, not only improving health outcomes, but challenging their social and economic status. This chapter will explore the theoretical underpinnings of this participatory model. Inspired by the work of Glenn Laverack (2006), I will focus on three domains of community-based participation: (1) participation and local leadership; (2) problem definition and evaluation; and (3) resource mobilization.

Community participation was prioritized in development and antipoverty programs during in late 19th century in Europe, and in developing countries, including India, in the 1920s. In 1948, the Cambridge Summer Conference on Africa Administration offered the first formal definition of community development:

A movement designed to promote better living for the whole community with the active participation, and if possible on the initiative of the community, but if this initiative is not forthcoming spontaneously, by the use of techniques for arousing and stimulating it in order to secure its active and enthusiastic response to the movement (Colonial Office in Jewkes and Murcott, 1998, p.844).

Community participation in international *health* programs became a major focus in the decades following World War II, leading to the international declaration of primary healthcare (PHC) at the Alma Ata Conference in 1978. The declaration stated that physician- and hospital-centered care failed to protect and promote the health of all people. Instead, health care needed to be

understood as a human right rooted in local social, political, and economic environments, and attuned to the needs and priorities of the underserved. Community participation was a major component of the PHC vision (Zakus and Lysack, 1997). As Halfdan Mahler, then Director-General of the World Health Organization (WHO), put it: “Health is not a commodity to be given. It must be generated from within” (Mahler, 1981, p.8).

The Tufts-Delta Health Center in Mound Bayou, Mississippi was a precursor to this global movement. More than a decade before Alma Ata ratified PHC as the health policy of all World Health Organization member nations, the Mississippi project embodied the goals of community participation and primary health care through its community-oriented primary care model.

Community Participation

What is community participation? David Zakus and Catherine Lysack (1998) describe it as:

...the process by which members of the community, individually or collectively and with varying degrees of commitment: develop the capability to assume greater responsibility for assessing their health needs and problems; plan and then act to implement their solutions; create and maintain organizations in support of these efforts; and evaluate the effects and bring about necessary adjustments in goals and programmes on an on-going basis (p. 2)

Zakus and Lysack’s definition treats members of a community as the actors who are gaining control over their lives and well-being. They are “developing the capacity to assume” these roles

in place of the usual power-brokers. Participation, then, is about people acquiring new responsibilities and skills that “have the potential to impact positively upon their health” (p.2).

How are participation and empowerment related? Susan Rifkin (1996) describes two theoretical approaches to these concepts. The first and oldest approach, called the target-oriented frame, is a scenario in which health professionals or planners set up a health intervention, like a vaccination program, and recruit the active acceptance of the intervention by local people. Through this target-oriented, “top down” frame, community participation is defined as the willingness of the population to accept the intervention intended to benefit them (Rifkin, 1996).

Rifkin’s second approach, called the empowerment frame, encourages people not merely to accept a health intervention, but to make decisions about resources and priorities and ask professionals to respond accordingly. For example, rather than outsiders defining a certain problem (e.g. malnutrition), determining the best solution (e.g. planting vitamin-enriched wheat), and then recruiting the intended beneficiaries to accept this intervention (e.g. rural subsistence farmers), this “bottom up” empowerment approach instead gives community members the space and authority to define problems and analyze solutions. It is a process of structural change by which relatively powerless people work together to increase control over events, resources, and decisions that affect their lives and health. Whereas the target-oriented frame sees community participation as “a means to the end of health improvement,” the empowerment frame views participation as “an end in itself” as it treats health care as a vehicle for social change (Rifkin, 1996, p.81-83).

Rifkin’s target-oriented frame is similar to the WHO description of participation as “contributive” or “organizational,” in which a community provides labor, cash, or materials to predetermined programs, possibly through an organized structure. In contrast to this passive

mode of participation, the WHO identifies “empowering participation” as a communal experience in which marginalized people take charge of their health care services (WHO 1991 Study Group in Woelk, 1992, p.420). The attainment of *power* and *control* is central to this process. So, too, is “consciousness.” Unpacking the forms of individual and community-wide change effected by empowerment interventions, Zakus and Lysack argue that the skills and experiences resulting from participation are a means to increased consciousness and control over life and resources (Zakus and Lysack, 1998).

However, consciousness is not only an outcome, but also a means to empowerment and social change. Brazilian educational theorist Paulo Freire (1970) explored critical consciousness (or *conscientizacao*) as a way for oppressed people to understand “*the way they exist in the world with which they find themselves*” [author’s emphasis] (p.83). Such awareness comes from questioning what one knows and making a conscious decision to see the reasons for the reality in which one lives. Freedom from oppression, Freire writes, can only be achieved when the oppressed achieve *conscientizacao* and use that knowledge to take action against the forces “interfering with the individual’s ontological and historical vocation to be more fully human” (p. 55). Like Zakus and Lysack’s analysis, this transformation engages participants as subjects, rather than objects, of their history and liberation.

Combining many of the aforementioned approaches, models, and theories, Laverack (2004) conceptualizes nine “domains” of community empowerment, in which a program:

- improves participation;
- develops local leadership;
- increases problem assessment capacities;
- enhances the ability to ‘ask why’;

- builds empowering organizational structures;
- improves resource mobilization;
- strengthens links to other organizations and people;
- creates an equitable relationship with outside agents; and
- increases control over program management.

Like Friere, Laverack sees critical consciousness as a major component of the empowerment process. “For participation to be empowering it must not only involve the development of skills and abilities...” which, he implies, can be passively transmitted and externally projected, “...but also a political concern to enable people to decide and to take action (Laverack, 2004, p.87).

Still, some scholars contest these participatory theories and models, expressing alarm at the way in which these concepts have been primarily used to win grants or project approval. G.B. Woelk (1992) argues that the definitions of words like “community” and “participation” are variable, frequently overlapping, and sometimes contradictory. For example, the WHO report cited earlier defined participation in three different ways: “participation as contribution, as organization, and as empowerment” (WHO 1991 Study Group in Woelk, 1992, p.420). Rifkin, Woelk summarizes, sees participation as “activeness, choice, and the possibility of the choice being effected” (Rifkin et al, 1998, in Woelk, 1992, p.420). Thus, there is limited consensus as to the precise meaning or purpose of these phrases.

The concept of “community” faces the same imprecision and diverse interpretation as “participation.” Woelk notes that some scholars define community geographically or culturally; others distinguish it based on its members’ shared interests; and others define community based on “at risk” characteristics. However, all of these definitions have a tendency to treat *community* as a homogenous unit. In reality, “even within a defined geographic area, community is made up

of different interest groups,” as well as stratified characteristics like religion, class, and gender. There is rarely, if ever, a monolithic “community.” Therefore, within different segments of the community, participation will mean different things and may present a range of opportunities, benefits, and burdens to various people (p.419-420). Critics argue that the vague, all-encompassing manner with which these terms are used weakens the meaning and efficacy of participatory approaches.

Finally, another critique by Lynn Morgan (1990) challenges the fundamental genuineness of participation, arguing that the concept was introduced and promoted by the United States in order to “promote a Western democratic political ideology” and, through what Woelk paraphrases as an “illusion of democracy,” to enable access to resources beneficial to American interests (Morgan, 1990, p.211; Woelk, 1992, p.420). Woelk conceptualizes these varying interpretations and hegemonic interests not simply as a problem, but as a *culture*. He argues:

There is after all a culture of professionalization and bureaucratization, and of power.

Though these interpretations are obviously predicated on differential access to status and power, and thus reflect structural relations, nevertheless a culture is created (Woelk, 1992, p.421).

Cultural influences, Woelk adds, are also relevant to the leadership structures of a participatory project. In many cases, leadership roles will fail to reach the most poor and marginalized people, since members of these groups will logically prioritize the basic needs of their immediate families over the expenditure of time, energy, money, or other resources needed to lead a community-based initiative. Community organizations may face this “trade-off between competent leadership and full representation” due to the way survival creates its own culture. Woelk writes:

Elements of this [survival] culture probably foster the world-view that open confrontation with the system is not productive, the system is opposed in a way which is not open...so as to avoid any counter-reaction. In any case, many, particularly small-scale communities tend to avoid open confrontation. In this context therefore, developing community organizations which, if they are to be effectively representative and foster 'true' community participation...is likely to be difficult (p.422).

Additional representation challenges arise not only when certain people in relatively more stable social and economic circumstances step up disproportionately for leadership roles, but also when elites seek to acquire or manipulate power positions out of self, rather than communal, interest. Ultimately, as Oakley et al. (1999) summarize, "culture is *not* an obstacle to community participation," but in order for a project to be successful, the culture of both community and outside agents must be critically examined "before participation is externally imposed" (Oakley in Morgan, 1990, p.225).

The transition from intellectual theory to hands-on practice reveals the greatest utility and challenge of any community development process. Taking into account the opportunities and constraints examined here, the next sections of this chapter will continue telling the story of the Tufts-Delta Health Center while exploring how the conceptual frameworks of participation were operationalized. I will focus on three domains of community-based participation, to each of which an individual chapter sub-heading is devoted: (1) participation and local leadership; (2) problem definition and evaluation; and (3) resource mobilization. I will then use the empowerment domains framework to unpack some of the limitations of the participatory model in Mississippi, and consider how varying levels of power, privilege, and control within a community affect the participation and social change processes.

Domain 1: Participation and Local Leadership

To begin their project, Geiger and Gibson picked Mound Bayou, Mississippi as the future site of the Health Center. Mound Bayou was one of ten towns in the project's 500-square-acre target area of Bolivar County. For years, blacks had worked as sharecroppers to the plantation owners in this region (Lefkowitz, 2007; Geiger correspondence 3/09). Nestled within this plantation world, Mound Bayou had been founded by former slaves in 1887. The town was a kind of oasis in the region. "It was all-black and... an uplifting [place] for people from the plantations," said L.C. Dorsey, a black woman who grew up on a plantation in the neighboring white-controlled town and later went on to run the Health Center. "They were our role model" (Dorsey interview 12/08). In an era when her stepfather walked her to the school bus with a shotgun on his shoulder, reminding her to stay in her place, not call attention to herself, and beware the Ku Klux Klan, the notion of black people working together to establish and operate their own town, school, and two hospitals was astonishing (Dorsey interview 12/08).

The September 1946 issue of *Ebony*, an African American magazine founded in 1945 which primarily showcased the positive achievements of black life and culture, included a feature article on Mound Bayou. The article paints an idyllic picture of the town, displaying photographs of "shacks in which most Dixie Negroes live" alongside Mound Bayou's "new modern homes" (p.24). Other descriptions cloak the all-black town in even greater flawlessness, explaining that:

the absence of a race problem flows from the lack of white men in the community; its crime rate is so low...[the] town has been without a jail for 15 years. Yet during that time not one major crime has been committed (p.23).

Beyond declaring a nonexistent “race problem,” the article positions Mound Bayou as a place indebted to Jim Crow.

In a real sense Mound Bayou is the highest expression of voluntary segregation. It is constantly being cited by nationalistic-minded Negroes in their efforts to prove that *Jim Crow pays solid dividends*. It is the all-Negro community of which the most rabid drum-beaters for planned segregation are most proud [emphasis added] (p.19).

In his interview for the article, Mayor Green argues that segregation is going to persist in the South for at least the next 100 years; accepting this fact and focusing common energies on developing the town will not only benefit local citizens, but “the Negro people everywhere in America” (p.24). In this way, local leaders identified Mound Bayou as a historic, heroic place far ahead of its time. However, their revolutionary aggrandizement was tempered by persistent acquiescence to Jim Crow and the white power structures operating in Mississippi.

The article also describes the Taborian Hospital, built in 1941 with funds from a local fraternal order called the Knights and Daughters of Tabor, as “Mound Bayou’s No. 1 showpiece” (p.23). The hospital, despite being built and run entirely by blacks and located in an all-black town, required fees that exceeded the means of the majority of local people. Nevertheless, the construction of the hospital, specifically, is credited in the article for “turning a ramshackle community into a model town” (p.23).

The hospital Geiger’s team visited upon arriving in Mound Bayou nearly two decades later was very different from what *Ebony* described. By this point, the Taborian had been joined by a second hospital in Mound Bayou, called the Sarah Brown Hospital. The Sarah Brown had split off from the Taborian some years before, and was also started by a fraternal order, the United Order of Friendship. Both hospitals were facing major financial troubles by the mid-

1960s. Under-equipped and understaffed, the quality of care at the hospitals had suffered due to financial pressures. Geiger and his colleagues felt this was not a result of poor management, but of systematic exclusion from the medical mainstream (Smith, n.d.).

Additionally, in order to use either of the hospital facilities, patients had to belong to one of the fraternal orders. These organizations functioned like health insurance companies, charging a monthly fee in return for access to ambulatory and inpatient care. They sold their health insurance policies in several counties in the Delta, including Bolivar County. On one hand, Geiger explains, the Taborian and Sarah Brown “served a critical need, for most white hospitals either refused to accept black patients, or demanded a cash payment up front, and then stuck them in the basement.” On the other hand, in a region of high unemployment, the fees required by the fraternal orders put hospital services out of reach for most of the poor (Geiger correspondence 3/09).

Historically, in order to maintain a reliable, strong source of labor, many plantation owners would allow black sharecroppers to see a white doctor, and some white doctors contracted with plantations annually for this purpose. However, this form of health care resembled the same race, class, and power demarcations of the larger sharecropping system. It “almost never meant being actually physically examined; the doctor asked some questions and wrote a prescription,” said Geiger (Geiger correspondence 3/09). Helen Barnes, a black physician from Mississippi who practiced obstetrics and gynecology at the Center, compared the poor sharecroppers to serfs in a feudal society. “You did not have control over your medical care or what you needed, even if it was seed to put in the ground,” she said. Health care, like other needs and services, was controlled entirely by the plantation owners who, at their discretion, made arrangements for a sick worker to be seen. Sharecroppers were not allowed to contact the

doctor themselves or pay directly for their services, and doctors received strict instructions to send any bills directly to the plantation owner (Barnes interview 12/08).

Medical care alternatives were limited. There was one white-operated black “hospital” in the county consisting of “a couple of old house trailers operated by an alcoholic white physician,” said Geiger. “[It] was so bad that even the state health department kept trying to shut it down” (Geiger correspondence 3/09). Some residents were aware of a county health satellite unit in the region, but it was only open a half-day-a-week and offered very limited services (Hatch, 1968). Herbal remedies and over-the-counter pain medications were generally the best poor blacks could access or afford (Dorsey interview 12/08).

Moreover, despite the supposedly tension-free racial climate portrayed in the *Ebony* article, the communities surrounding Mound Bayou were hardly immune from numerous forms of individual and institutional racism. As War on Poverty funds trickled down to the region, whites in neighboring towns believed that giving federal aid to poor people would “make them lazy” (Hatch interview 8/08). In one instance, this myth led a local white sheriff to take a shipment of food that arrived to be distributed to the poor and dump all of it into the river. Authorities “could do just about anything they wanted to, especially involving poor people and black people,” said Hatch (Hatch interview 8/08). Thus, despite the challenges Mound Bayou and its surrounding communities presented, its attraction was two-fold: “Mound Bayou’s locally autonomous black government, would provide a safe place for what would inevitably be a racially integrated project and staff,” Geiger said, “and we would need access to hospitals to do our health care job” at a time when gaining access to surrounding white hospitals was not an option (Geiger correspondence 3/09).

With the 1940s invention of the double-row cotton-picking machine and chemical herbicide, a plantation that had once needed hundreds of laborers could now accomplish the same work with a few mechanical harvesters and farm hands. Within just a few years, the sharecropping system in the Mississippi Delta vanished. With it disappeared the plantation owners' economic self-interest in protecting the health of the population. Dorsey recalled:

When they really started using the herbicides, we were on the Dickson plantation. And we just wasn't needed. We just wasn't needed. It was over so quickly without you thinking it was coming (Dorsey interview 12/08).

The former sharecroppers now faced an unemployment rate as high as 75 percent (Geiger in Hollister, 1974). Many young people migrated to Northern cities in search of jobs. Left behind were high concentrations of the young, old, and sick (Geiger, 1969). Hatch estimated that one-third to one-half of children were being raised by grandparents or surrogate parents while their biological parents migrated north to the "land of opportunity" with the understanding that they would send money back and, eventually, send for the rest of their families (Hatch interview 12/08). Due to increased unemployment and social disruption, the state's black infant mortality rate was 54.4 deaths per 1,000 live births, more than twice the rate for whites and 25 percent higher than national black infant mortality rates (Lefkowitz, 2007). Ninety percent of households lacked baths, showers, and toilets and most black people received no more than five years of formal education. The education they received was almost always at segregated and inferior institutions (Lefkowitz, 2007; Geiger in Hollister, 1974; Geiger, 2002; Geiger, 1969).

With the go-ahead from the OEO in 1965, health center planners launched their community organizing efforts. John Hatch, an African American social worker and community organizer who had grown up on a family farm in rural Arkansas and later worked as deputy

director for the Boston Housing Authority, served as the head of the Health Center's community organization department. When Hatch had first traveled to Mound Bayou to learn about the area, Geiger recalled, he disappeared for three weeks. "I got very nervous. This was 1966!" Geiger said, referring to the racial violence and lynchings that occurred frequently in the region. Hatch finally returned, explaining to his worried colleagues that he had picked cotton for three weeks in the Delta as a way to get to know the local people and lifestyles (Geiger interview 11/08).

The familiarity and trust Hatch developed with the community was invaluable to the project's early success. Under his guidance, local residents hired as community health workers knocked on the doors of every black family in the county and met with people in churches and schools. They explained the health center model, and invited others to participate (Geiger in Hollister, 1974). After working slowly and patiently for over a year, Hatch and his staff organized ten Health Associations of poor Bolivar County residents. The Associations each chose a representative to serve on the North Bolivar County Health Council. The Health Council served as the Health Center's advisory committee and, later, its governing board (Lefkowitz, 2007, Geiger correspondence 3/09).

The Health Associations were built on the foundations of the black church, an institution with which people felt most culturally and socially familiar (Geiger interview 11/08). In addition to specialized electoral methods, which ensured that family members and friends didn't have to vote against one another, the Associations borrowed other characteristics from the black church, including the distribution of services and resources to members in times of need, the use of easily remembered phrases to describe common purpose, and the notion of maximum participation through division of labor (Citizen Participation, 1967).

The process of setting up the Health Associations and Health Councils in an inclusive, culturally relevant manner was a critical step in developing participation and local leadership. These organizational efforts helped the poor to come together in groups to define, articulate, and address their needs and priorities, while developing interpersonal trust and social bonds (Laverack, 2006). None of this happened overnight, and Hatch faced major pressure from the OEO, which was eager for fast progress and community involvement. They “kept screaming ‘Where is the board? Where is the board?’” (Geiger interview 10/08). While built on a familiar church-based model, involvement in the health organizations was a very new experience for people “who had never been asked to participate in anything before” (Hatch interview 8/08).

Many people were resistant to the idea of taking a leadership role in the health organizations, assuming that they lacked the appropriate the necessary skills or experiences.

Hatch recalled:

Their first reaction often was, “Gee, I never think about these things.” And I’d say, “You live in this community, you raised children, you know what that’s like. Do you know any old people who need help?” We had to really state the rationale for citizen participation and then ask the poorest people in the nation to give their time to come out to meetings and talk about it (Hatch interview 8/08).

The poor community of Mound Bayou had leaders; however, they were “less visible...it wasn’t in the newspaper, but in their social networks” (Hatch interview 8/08). Hatch developed socially and culturally sensitive strategies to identify that web of internal, informal leadership. For example, in organizing orientation talks about the health center concept, Hatch found that mass meetings rarely attracted people. However, when he provided refreshments and asked people to host casual evening talks on front porches, crowds started showing up. Hatch believes this was

partly due to the “the entertainment value” of the Health Center staff, and partly because the poor blacks felt more comfortable expressing themselves in small, informal groups. As local residents invited friends and neighbors, Hatch started to learn more about their social networks and to identify the most trusted members of the community from whom others sought advice, support, and friendship (Hatch interview 8/08).

One such person was Joe Clemson. Clemson worked on a cotton plantation and was charged with overseeing the agricultural laborers there. He was a hard worker who “made the plantation owner...a very rich man” and felt proud to bring in a successful cotton crop year after year despite the fact that he was still living in a house without plumbing. He was also the chief deacon of his church and was someone to whom others turned when they were in trouble. In a meeting with Clemson to introduce the health center project, Hatch asked him:

‘Well, what are some of the things that you think we might do to make life better for people with young children?’ And [Clemson] kind of looked around and said, ‘Well, you know, Brother Hatch, I’m mighty impressed with you. I think you’re one of the smartest young men I’ve seen in many years. And I probably think that *you* know what’s good for us. So why don’t you just tell us’ (Hatch interview 8/08).

The meeting with Clemson gave Hatch a new appreciation for the extent of powerlessness affecting the rural poor. Most were unaccustomed to having a say about community-wide issues or offering their opinions to people of greater privilege and power—black or white. He understood that Clemson’s response to his request for feedback was common: “Well maybe [Hatch] might be able to help us, so we don’t want to upset him, but we don’t know what in the world this man is talking about!” (Hatch interview 8/08). It took multiple conversations for trust and mutual understanding to develop between the two men. At the same time, Clemson, himself,

came to acknowledge that “while he had pride in his work, he also had a lot of anger—that the world shouldn’t quite be the way it had treated him” (Hatch interview 8/08).

Many of these community members who were drawn to the health center project had developed community organizing experience through civil rights movement activities, or through the War on Poverty program that preceded the Health Center in Mississippi, Head Start. Offering services from education and food to disability support and jobs. Head Start was one of the first antipoverty programs in Mississippi “that represented change and offered opportunities for people to have some say in the outcome,” said Dorsey (Dorsey interview 12/08). The opposition Head Start faced in Mississippi also provided instructional examples as Geiger’s team wrestled with many of the same players and problems.

In short, the early health center project was committed to a bottom-up participatory approach, although the idea, location, and strategy for the project was initially dictated by outsiders. Participation and local leadership developed steadily, beginning with Hatch’s earliest efforts to pick cotton with and learn from the local poor about their struggles and strengths. By slowly building mutual understanding and trust, Hatch was able to design a structure of health associations (based on the model of the black church) that opened doors to dialogue, awareness, and action. These structures also offered the opportunity to reach out to less visible leaders in the community, including those with previous leadership experience and those without. Ultimately, the Tufts-Delta Health Center’s community organizing approach was different from organizing rural populations for a one-time march or protest, and it sought at all costs to avoid “domination by those with more education, organizational experience, or verbal skill” (Hatch, 1968; Progress Report, 1970). However, with its own socioeconomic gaps widened in the post-mechanized

agricultural era of increased migration and unemployment, Mound Bayou was hardly immune from class pressures and disruptions.

Domain 2: Problem Definition and Evaluation

The project was met with some skepticism and distrust by the poor population it hoped to serve. Many had known or heard of somebody who had been part of the infamous Tuskegee Syphilis Study, a clinical study conducted between 1932 and 1972 in which hundreds of poor African American men were used to observe the natural progression of syphilis without medical treatment, even for years after penicillin came into use. The community was also aware of a local scandal in which people had been stealing black people's kidneys and running an illicit underground kidney bank for white people. There was some "fear and some concern about why [Tufts would] come down here and give us free health care," explained Dorsey, whose initial role in the project was to educate residents, reassuring them that the health project was safe and trustworthy (Dorsey interview 12/08). There were also myths that a health center would "pick everyone up who had syphilis or some other bad disease and ship them *out* of the community" (Dorsey interview 12/08).

At times, Dorsey recalled, some of these fears were actualized. After the Center was established in Mound Bayou, Tufts University researchers expressed interest in collaborating with the state prison, located near Mound Bayou, to use Mississippians as subjects for testing a new drug they were developing. Dorsey's physician at the Center assured Dorsey that the subjects would "be fully informed....lives would not be taken for taking this stuff, [the researchers] just wanted to see how it would affect them" (Dorsey interview 12/08). Nevertheless, Dorsey and most of her colleagues knew how detrimental it would be to the

vulnerable community and to the health center project, and effectively defeated the proposal (Dorsey interview 12/08).

In churches and front-porch meetings, the Health Center team explained the various parts of their comprehensive model, like preventative care, home care, and environmental improvement. But community members often stole the spotlight and returned the project to its COPC roots. At one memorable meeting, Hatch recalled, a woman stood up to “thank the Lord for Tufts University and the United States, and all those people who sent ya’ll down to help us to try to get well,” before wondering aloud if it might first be helpful to get food and clothing and shoes for all the people who desperately needed these items (Hatch interview 8/08; Hatch, 1968).

The woman’s suggestion, and the comments from her like-minded neighbors, marked a critical juncture in the project. As they came to reflect on the underlying causes of their powerlessness and poor health, community members contested preexisting approaches. “They were reminding us why we had gone there in the first place,” said Geiger (Geiger interview 11/08). While community members didn’t see clean water, adequate food, and available jobs as health issues, per se, they certainly saw them as urgent quality of life issues. An enhanced awareness allowed the community to reflect on underlying approaches and articulate new ideas.

This consciousness redefined the local understanding of the roles of Geiger, Hatch, and the other Health Center staff who became seen as “problem solvers and helpers, rather than just as health people” (Geiger interview 11/08). As the Center worked with the community to address key issues and priorities, the community, in turn, became more interested in more traditional clinical services offered by the Center (Progress Report, 1970). The health practitioners learned “that you can bring all the pills and instruments you want,” said obstetrician Helen Barnes, but if people can’t feed their children and if they can’t feed themselves, you have

to go back to the first page” (Barnes interview 12/08). As Barnes’ comment illustrates, the Mound Bayou “model” of health care delivery and social change did not originate in a medical textbook or conversation between professionals, but was shaped by the community’s most urgent concerns.

As the community and professionals searched for common understanding of local *priorities*, they also sought mutual agreement on definitions of *problems*. For Hatch and Geiger, the primary measure of the Health Center’s success would be lowering infant mortality. For community members, this approach was ludicrous. “Some babies are going to die,” they told Hatch (Hatch interview 8/08). The infant mortality rate was not perceived as the priority, nor was it something they believed they could control. “They’d always had high infant mortality. What they *hadn’t* had was old people living alone during their older years, people dying alone,” explained Hatch (Hatch interview 8/08). The notion of elderly people living alone, unable to care for themselves, was considered unacceptable by community members; it was therefore a point of appropriate intervention for the Health Center project and its professionals.

While Hatch organized the community, Geiger’s efforts to organize the Health Center faced a major problem: finding a home. When it passed the OEO Act, Congress would not allow War on Poverty funds to be spent on building infrastructure. This prevented Geiger’s team from constructing a facility from scratch, but they hoped it might be permissible to renovate an existing space. A year passed as they waited to find such a building. As the provision of direct medical care continued to be delayed, Geiger grew increasingly anxious about the “risk that this was going to look like “pie in the sky” [to the community], who wanted to know where all the doctors were” (Geiger interview 11/08). As a temporary fix, the health team rented an abandoned movie theatre for training aides, some storefronts for a pre-natal clinic, and space in a Baptist

Sunday school for staff and nursing offices. The living room of the church parsonage was transformed into a waiting room, its bedrooms into examining rooms, and the kitchen into a lab (Geiger interview 11/08).

Looking back, Geiger sees this delay as somewhat fortuitous. It enabled the first year to be focused on organizing the community, hiring and training health center staff, employing local residents to conduct a census and health survey, and providing outreach and home visits by public health nurses and nurse-midwives. “It was during this period that people began to raise issues beyond medical care,” he said (Geiger correspondence 3/09).

However makeshift, clinical health services for the poor finally had a home. The trickle of people was slow the first day, with only 10 patients visiting, most sent as “scouts” by their families and neighbors. The following day there were 30 patients, and the next day there were 100. Within a short time, the Center was overwhelmed with people seeking care. Another overwhelming aspect was the demographic representation of patients. Well aware of the extent of malnutrition and disease affecting children from earlier studies and observation, Geiger had primarily recruited pediatricians to Mississippi. Most of the initial patients who came in were not the children he expected, however, but older people with hypertension, arthritis, and other neglected chronic diseases. The health professionals on staff were not always accustomed to caring for these types of populations, and for the conditions and illnesses from which they suffered (Geiger interview 11/08).

The community members were also unaccustomed to the health providers. At times, discomfort arose over the fact that the health providers from the North were racially, economically, and ideologically different from the health consumers whom they served. “When people found out that Jack Geiger couldn’t distinguish between a bean plant and a cotton plant,

they were shocked. “ ‘But he’s a doctor!’” they exclaimed. “And he can’t tell the difference? Where’d he go to school?’ Everybody there, except these folks, knew the difference” (Hatch interview 8/08). Even though John Hatch was black and originally from the South, he, too, stood apart by virtue of his education and the Northern job he left to return to the South. “I would be perceived as a high school principal or some big person,” he said. “This is an environment where teachers are big people. Deputy sheriffs are like the U.S. Attorney General in terms of their perceived power” (Hatch interview 8/08).

As far as the clinical setting was concerned, Dorsey credits the way the health professionals Geiger recruited broke down many of the fears and barriers that may have otherwise alienated their poor patient base. Doctors called patients by their courtesy titles, spoke slowly, used flipcharts and other devices to give accessible explanations to a mostly illiterate population who lacked an understanding of the “biological factors and misfortunes...that brought them to the clinic” (Dorsey interview 12/08). Dorsey also saluted the Health Center on its commitment to always making people aware of their treatment options, including the right to *refuse* treatment—an awareness all the more urgent in the wake of Tuskegee and even Mound Bayou’s own brush with proposed experimentation on vulnerable subjects (Dorsey interview 12/08).

For the idealistic health professionals who migrated to Mound Bayou, providing services to long-neglected people was not the only challenge. Many amenities that professional families had come to expect, including educational opportunities for their children, did not exist in this poor, rural environment. However, support provided by Tufts, including legal services, academic awareness, and “pathways in as well as pathways out” enabled a level of functioning “that probably couldn’t have been achieved by one or two people or without substantial institutional

resources” (Hatch interview 8/08). Most staff stayed only three or four years. Recruiting black physicians was a great challenge. However, there were a number of young black physicians who had migrated north and had decided to return south for the purpose of working in the Health Center. “That in itself was something of a revolution,” Hatch explained. “The civil rights movement...gave them hope to believe that the South could become a viable place to practice” (Hatch interview 8/08).

Due to a legacy of negative interactions with the health care system, community members expressed skepticism and fear towards the Health Center project. Some of these fears, like becoming victims of medical experimentation, proved to be realistic threats that the project had to confront and prevent. As familiarity with the Center and health professionals grew, the community asserted its authority in identifying problems, designing solutions, and framing evaluative metrics. Their inquiry, reflection, and reaction embodied Freire’s concept of critical consciousness: by identifying the issues most important to them, they avoided having outside agents simply assume “needs” or impose interventions (Laverack, 2004). At the same time, health professionals came to redefine their own identities and responsibilities within this shared space. Their own priorities and problem definitions shifted as the impossibilities of practicing effective primary care, raising a family, or living as a physician of color in an under-resourced and segregated rural setting were proving viable.

Domain 3: Resource Mobilization

By seeking agreement on common problems and priorities, the Health Center was able to work with the Health Associations and Health Council to devise multifaceted interventions, from digging wells and controlling rats to offering high school equivalency and college preparatory

courses (Hatch interview 8/08). Andrew James, the Center's director of environmental services, trained local residents who passed the state examination to become the first ten black registered sanitarians in Mississippi history (Geiger correspondence 3/09).

Another critical need was food. Realizing that food stamps and other aid programs were not reaching most poor families, the Health Center developed a system of writing prescriptions that enabled the parents of malnourished children to go to one of the black-owned grocery stores in town and get several weeks worth of food for the whole family, based on the principle that "the best therapy for malnutrition was food" (Progress Report, 1968; Geiger correspondence 3/09). The store could send the bill to the Health Center, and the Health Center would pay this bill with its pharmacy funds (Geiger keynote, 2005).

But John Hatch had another idea. Recognizing community members' agricultural skills and thirst for jobs, and the rich land in the area, he thought, "wouldn't it be a better model to give them the resources and let them generate a significant amount of their [food and] income at the same time?" (Hatch interview 8/08). Within days, no less than 200 families expressed interest. The co-op began with one hundred acres of land, loaned or rented from local black farmers. Through a substantial grant from the Ford Foundation, funneled through the Federation of Southern Cooperatives, it expanded to a 500-acre, 1000 family farm cooperative that grew over a million pounds of food, rather than cotton (Geiger in Hollister, 1974; Geiger correspondence 3/09; Hatch, 1968). Additional funding for important equipment came from an OEO emergency food aid program after the project leaders convinced the OEO that "it made more sense to enable people to grow their own food than simply to provide funding to buy food and hand it out" (Geiger correspondence 3/09). Much was consumed locally, and the rest was exported to bring in

additional revenue. The Co-op leaders also established an African American-themed bookstore, clothing recycling shops, and other business ventures (Dorsey, 1990).

In addition, the black-owned, black-run project was a significant historical, cultural, and psychological resource for poor blacks in Bolivar County. This unifying, identity-shaping process again relates to Freire's concepts of critical consciousness, and also to Muller's (1983) work in Peru, showing how a "common history of struggle" can broaden and improve participation (Muller, 1983, in Woelk, 1992, p.422). For centuries, whites had mostly prevented blacks from owning land in the South in order to perpetuate their economic immobility and total dependence on white masters. As Hatch wrote:

In the south, land has always been and continues to this day to be a primary requisite for economic independence...When one owns land his sense of independence or his sheer ability to stay alive supports the development of personality characteristics that lead men to demand that they be treated like men. The black pioneers for change have been those who felt that they could survive come hell or high water. Both hell and high water often came. The black man's holdings became not only his castle but also his fortress against a society that was as determined to prevent his rising (Hatch, n.d.).

During the civil rights era, Hatch acknowledged, land ownership held particular significance.

"The system knew that [land] ownership often led blacks to 'crazy thinking' like demanding the vote, educating his children, requesting services from public agencies" he wrote in one report (Hatch, n.d.). In the post-sharecropping era, the North Bolivar County Food Cooperative was a major advance for previously landless blacks in Bolivar County—providing food, employment, collective ownership of land, and a share of generated profits to a population who no longer answered to or relied on plantation owners.

The Co-op nurtured bodies, minds, and incomes while serving as a sign of formative progress and hope for a highly disadvantaged population. It gained support from local black farmers, who offered the Co-op about forty acres of their fallow land for free when the project was beginning, and collaborated with outside institutions like Mississippi State University. When the Co-op leaders described their plan to the agriculture faculty at Mississippi State University, the faculty:

were so intrigued by the idea that the Delta might diversify into vegetable gardening, instead of just cotton and soybeans, that they sent a senior consultant to work with the farm manager, both to lend technical advice and to study the project (Geiger correspondence 3/09).

In addition, the owner of one of Bolivar County's largest white plantations was so impressed by the self-help project that he loaned the Co-op critical farming equipment (Geiger correspondence 3/09).

In these ways, the project became a form of resource mobilization, which Laverack defines as the ability "to mobilize resources from within and to negotiate resources from beyond itself" (Laverack, 2006, para. 20). Most importantly, the Co-op included education and literacy programs in its efforts—a combination which is necessary for enabling an oppressed population to gain social and political power, and improve health outcomes (Laverack, 2006). Thus, the Co-op exemplified the mobilization of what Goodman et al (1998) refer to as "traditional capital," including money and property, and "social capital" which includes collaboration and trust within and between communities.

Other accomplishments exemplify this resource mobilization and social change process. When the Health Center was set up in Bolivar County, loans or mortgages were given to blacks

at illegally high interest rates, and only if there was a white co-signer. Members of North Bolivar County Health Council saw a major opportunity:

Realizing that the Health Center was receiving more than a million dollars in grants and other cash flows each year, [they] visited all the major banks in Bolivar County to negotiate which bank would be chosen as the depositor. Their terms: (1) a branch bank in Mound Bayou, with blacks as branch manager and tellers, not just janitors; (2) mortgages on fair terms to black employees of the health center and others with good jobs, without co-signers or other unusual guarantees (Geiger correspondence 3/09).

The large economic incentive alone was enough to convince the smallest, previously most racist bank in the county to sign on enthusiastically. This precedent enabled housing development for blacks “not just in Mound Bayou but in the other areas of the northern county where employees lived,” said Geiger (Geiger correspondence 3/09).

Chapter IV: Opposition to the Project

The Tufts-Delta Health Center project was rooted in a community participation model that approached health intervention from an empowerment framework. This approach allowed relatively powerless people to gain control over decision-making and resources, not only improving health outcomes, but challenging their social and economic status. The preceding analysis of the “domains” of community empowerment helps us to understand more specifically the steps by which this empowerment approach operated in Mound Bayou and its surrounding communities. As such, the early health center project developed participation and local leadership; enhanced problem definition and assessment capacities; and improved resource mobilization. However, not everyone in the region was appreciative of the Health Center’s participatory approach. I will now turn to sources and impacts of opposition, and the ways in which these dynamics inform a more nuanced understanding of empowerment and community.

Opposition by the White Political and Medical Communities

Even before the Health Center was constructed, the proposal drew vigorous resistance from the Southern white political and medical communities. Mississippi’s conservative medical establishment “towed the politics of the state,” said Robert Smith, a native Mississippian who co-founded the Medical Committee for Human Rights and served as a physician at the Tufts-Delta Health Center (R. Smith interview 12/08). Blacks physicians were excluded from local state and county medical society meetings and social functions, and struggled to gain hospital appointments, which required the signatures of three (white) physicians (R. Smith interview 12/08). White doctors feared the project would cause them to sacrifice racial and economic

dominance in Mississippi. They were enraged by the fact that OEO funds “would bypass the gatekeepers...and go directly to black communities,” said Geiger (Geiger interview 11/08). In meetings, letters, and phone calls, Geiger was bombarded by the same message: political disapproval, fear of economic threat, and suspicion of outsiders (Geiger interview 11/08).

Geiger expected this opposition, and did not see it as insurmountable. He had reviewed federal law establishing the OEO and knew that approval of the project by the state was not required, nor did the state have any legal means by which to block it. When the OEO law had first been negotiated, the Southern governors insisted on a provision that a governor could veto any OEO project in their state, hoping to avoid losing control over funds to black communities and organizations. As OEO director, Shriver could override that veto, but such a move “would require the expenditure of political capital in a budget that had to be passed by the Congress each year” and, Geiger explained, “wasn’t likely to happen too often” (Geiger interview 11/08).

However, in the hopes that the University of Mississippi and the University of Alabama would easily have access to OEO money, Southern members of Congress added a rule exempting institutions of higher education from governors’ veto power. However, there was nothing in the grant that said the OEO couldn’t give a veto-proof grant to an institution in Massachusetts to conduct a project in Mississippi. “Tufts was an institution of higher learning; therefore, there was nothing the Mississippi governor or legislature could do to block it,” said Geiger (Geiger correspondence 3/09; Geiger interview 11/08). The goal, therefore, was not that the government or medical community “welcome, endorse or approve” of the Health Center project, but that they merely agree to “official neutrality or toleration” (Current Status, n.d., p.6, 11).

Furthermore, there were some “at least covertly” sympathetic white physicians and government officials in the region (Current Status, n.d., p.11). Before the project began, Geiger met with Dr. Hollingsworth, one of the only private physicians practicing in a town near the health center, whom Geiger imagined would have some of the greatest fears of competition. During their meeting, Hollingsworth told Geiger about his work as a Baptist missionary volunteer at a hospital in Haiti, and about his progressive views on race, which he felt he had to keep silent for fear that his colleagues would “run him out of town” (Geiger and Bellin, 1966, p.23). Geiger met many other white physicians throughout Mississippi who were “interested and friendly” but similarly fearful of how their reputations or personal safety would be jeopardized if they spoke publicly of their support for civil rights and health care for the poor (Current Status, n.d., p.11).

At a meeting Geiger had with more than sixty local doctors from the area, the project proposal was attacked, and the doctors voted 40-1 against it. Yet Geiger was elated. First, almost thirty of the men had abstained, which Geiger took to be votes of support. Second, he would soon discover that many of the people who presented themselves as his adversaries were, in a certain sense, allies. At a dinner-dance sponsored by the Delta Medical Society he attended that night, several of the physicians patted him on the back. One said:

I’m a rabid segregationist, grew up on a plantation, lived in this place all my life, member of the White Citizens Council, that’s where I stand and I just want to tell you, you’ve got a lot of guts and I respect you—if I’d been in your shoes, I could no more have stood up in front of that whole bunch you had in that room today and laid it out that way, the way you did. You and I may disagree, but I can respect you (Geiger and Bellin, 1966, p.37).

Before the night was over, ten more physicians voiced the same message. As Geiger stepped onto the dance floor with the wife of the president of the medical society, he realized that even the most arch-segregationists and critics of the federal government were aware of the scope of problems facing Mississippi blacks, but were unable to risk their reputations by taking a stand (Current Status, n.d.). “There were physicians of good will who were willing to help,” Geiger said, “as long as it was never a matter of public record where they were exposed for doing it (Geiger interview 10/08).

From the perspective of Aaron Shirley, the first black doctor to train at the University of Mississippi and the only black pediatrician in the state at the time he was working at the Health Center, the project center represented a threat to what whites called “the Southern way of life” (Shirley interview 12/08). Past, present, and future segregation was the underlying principle of this way of life, which depended on nearly total disenfranchisement of blacks to prevent them from having any political power (Geiger correspondence 3/09). Plantation owners or government officials maintained it for example, by firing a black person if he or his family member participated in a civil rights demonstration. The government also pitted poor whites against poor blacks to uphold this status quo. Although poor whites suffered along with poor blacks, officials framed the Southern way of life as something poor whites stood for and poor blacks threatened. Officials used fear tactics around integration and interracial marriage to boost whites’ resentment of their black counterparts, just as they were able to frame community health centers—whose employees would be immune to job threats by white officials—as a threat to the Southern way of life (Shirley interview 12/08).

Opposition by the Black Middle Class

However, the Health Center's biggest struggle was not with the white power structure of Mississippi; it was with a group of members of the black middle class of Mound Bayou. "It was people who had money, who had education, who had political connectedness who exploited the original intent of the town," said Dorsey (Dorsey interview 12/08). These black elites—elected officials, teachers, and store owners—saw themselves as oppressed in relation to Southern society at large, but also part of a special network in charge of the rest of the all-black town. They were a "caste within a caste system...who understood the dynamics of what political power and money meant in society," said Mississippian physician Robert Smith (R. Smith interview 12/08).

Elites spent years trying to gain control of the Health Center's resources, claiming to be "the ones who, all these years, have looked after our less fortunate brother....so just let us handle it" (Hatch interview 8/08). Despite what Smith calls their "village mentality," they were not authentic leaders of or advocates for the poor majority of Bolivar County (R. Smith interview 12/08). Hatch's community organizing strategy from the beginning aimed to empower the poor as a force for social change. He was careful to avoid "granting" representative authority to assertive, ambitious elites whose skin color, but not interests or experiences, were shared by the underserved poor (Hatch interview 8/08).

Nevertheless, Mound Bayou elites fought hard for control, fearing that the War on Poverty project could upset their social status and pose an economic threat. Since the Health Center was required by federal law to pay its entry-level employees minimum wage, people who had once been dependent on earning income from elite members of Mound Bayou were no longer restricted to this arrangement. "A woman [living] in a plantation shack hired by the high

school science teacher to clean his house, often with a demand on the side for sexual favors” would suddenly be earning as much money as he. She “could now could tell him...he could take that job and shove it,” said Geiger (Geiger interview 10/08). Elites did not respond well to this rearrangement of longstanding social hierarchies. In one case, a drunk man “came tearing into the Health Center, waving a gun, and looking for ‘Mr. Tufts, who stole my woman’,” remembered Geiger. “He [said he] was going to shoot him because his woman had told him off.” She had recently been hired at the Health Center (Geiger interview 10/08; Geiger correspondence 12/08).

Robert Smith saw these power struggles as a replication of an oppressive patronage system—a paradoxical consequence of centuries of being bought and sold. “There were blacks who simply wanted more, a bigger share of the pie,” he said. Mound Bayou’s unique and proud position as an all-black town may have amplified these interests. When the project leaders were first considering setting up the Health Center in Mound Bayou, Amzie Moore, the veteran activist and head of the NAACP in Cleveland, Mississippi warned Hatch against that choice, pointing out that Mound Bayou had done little or nothing to contribute to the civil rights movement. Moore explained that the Mound Bayou middle class “think they're already free” since they had their own town government and could vote, at least in local elections (Geiger correspondence 12/08). Many of these residents saw themselves as “superior to the poor and displaced sharecroppers and black workers in the other towns and rural areas of Bolivar County,” who lived under white control (Geiger correspondence 3/09).

One of the earliest examples of the elites’ attitudes towards the Health Center occurred during the Center’s construction, involving one of the most prominent citizens of Mound Bayou and most vocal critics of the Tufts project, Dr. Burton. Burton ran the Sarah Brown Hospital.

Like its sister hospital, the Taborian, the Sarah Brown refused to treat people who failed to pay their dues to the local fraternal order. When the foundations of the Tufts-Delta Health Center were constructed, the contractor of the project told Geiger that “Burton had offered [the contracting company] \$5,000 to blow it all up.” Burton saw the Health Center as a direct economic threat and believed that the doctors at the Center were going to take all his patients (Geiger interview 11/08).

This fear of economic competition had little basis in reality, explained Dorsey, since the Health Center primarily served people who lacked insurance and a source of private, primary health care. In addition, its patient base spanned town and even state lines, with some people coming in from Arkansas and Louisiana (Dorsey interview 12/08). Nevertheless, the resentment of Dr. Burton and his counterpart at the Taborian, Dr. Lowry, illustrate some critical tensions that were exposed and exacerbated by the Health Center project.

One source of tension was income disparity. At the time the Health Center was established, Robert Smith explained, physicians in Mississippi (including himself) were making \$5,000 or less per year. When the Tufts project came in, its predominantly white physicians were paid by the government, making more than \$30,000 a year. Dr. Smith explained:

At that point in America, it was racial. It created a hell of a lot of tensions in the sense that on one hand the motives were right, but the reality was that we had two black physicians there who were the head of these hospitals, who were making nothing. It was more of what black people saw as typifying America. It was not a participatory democracy (R. Smith interview 12/08).

This perceived economic and racial inequity was part of a larger set of cultural power struggles occurring through, and amidst, institutional structures. Contestation over local power and

governmental resources not only involved the Health Center and the hospitals, but also their academic affiliates.

The Taborian Hospital had had a longstanding relationship with Meharry Medical College in Nashville, Tennessee, one of the only medical schools in the country that trained black doctors. The Chief of Surgery at Meharry, Dr. Matthew Walker, sent residents down to rotate for three month periods through the Taborian. “They provided the bulk of the medically trained professionals...to operate those [hospitals],” said Dorsey. With years of involvement and virtually no federal or state support, Meharry “kept that program going out of their back pockets” (Dorsey interview 12/08).

From Geiger’s point of view, the arrangement was a mixed blessing. On one hand, the Meharry residents were “by far the best trained physicians that the Taborian had. On the other hand they were virtually totally unsupervised” (Geiger interview 11/08). On at least two occasions, Geiger publicly criticized the local hospitals’ quality of care and supervision: once at a public meeting with Meharry representatives present; and another time in a *LIFE* magazine article in which he was quoted as saying that he and the Tufts staff “were practicing missionary medicine...where virtually none existed” (Hall, 1969, p.4). Looking back, Geiger acknowledged that the Taborian and Meharry staff took this as an insult because saw themselves filling an important need that Tufts had not been the first to address (Geiger interview 11/08).

Their response was symbolic, Dorsey explained, of the larger anger that Meharry faculty and students felt as a result of their exclusion from the Tufts project. “[W]hen Tufts got involved in Mound Bayou it just seemed like truckloads of money were available,” said Dorsey. “Medical students were able to be brought in from all of the medical schools...[but] very few were brought in from Meharry” (Dorsey interview 12/08). Dorsey acknowledged that the “bitter taste

in the mouths of Meharry” lasted for decades. When doctors at a meeting at Meharry in the 1990s found out Dorsey was a *de facto* representative of Tufts, they displayed animosity towards her. Dorsey does not blame Tufts or Geiger for this tension, but thinks that a much healthier partnership could have been established between Tufts, Meharry, and the local hospitals if the U.S. Public Health Service, which had knowledge of these institutional dynamics, had properly advised the project (Dorsey interview 12/08).

Whether the negative reactions of the black middle class and health practitioners towards the Tufts-Delta Health Center were rooted in a feeling of resentment, insult, racial discrimination, or greed, the ripple effect was essentially the same: the black power structure largely voted out of self interest rather than collective interest. Failure to embrace systemic change or racial uplift reflected and exacerbated the frayed social contract between the black middle class and the poor.

The impact of these power dynamics and local incidents on the Health Center was mixed. On one hand, it was a drain on the Health Center’s time and personnel. Geiger sometimes felt “consumed [by] the struggle” with elites and the extent to which it limited his time in other capacities (Geiger interview 11/08). In some ways, however, the conflict served a positive role. It signaled social and economic disruption, helping the poor to become more aware of their impact and strength, and catalyzing the involvement of greater numbers of the population in the project (Hatch interview 8/08). In addition, opposition by middle-class blacks was common, but not town-wide. “There were established Mound Bayou people very much in support of us,” Geiger recalled, including Preston Holmes, the postmaster, and his wife, along with the Health Center’s nurses, nutritionists, and other local employees (Geiger correspondence 12/08).

At the helm of the elite campaigns for control was the most prominent adversary of the Health Center, and the mayor of Mound Bayou, Earl Lucas. Lucas “grew up in a family of elites and his contempt for the poor was as contemptible as any white person,” said Shirley (Shirley interview 12/08). From the moment the project broke ground in Mound Bayou, Lucas saw the Health Center as an economic and social threat, as well as a way to gain power for himself and his associates.

When Geiger’s team first arrived in Mound Bayou, Lucas had not yet been elected mayor, but was serving as director of a job placement initiative. Lucas wanted the Health Center to let him control its hiring. Geiger explained to Lucas that it wasn’t possible to give up control of their hiring, though the Center would be happy to add his referrals to the applicant pool. At this point, the Health Center had already hired Lucas’ wife, Mary Lee, for the nursing staff. “RNs were hard to come by, and a local one seemed to be a plus,” said Geiger. “What we didn’t know, of course, is that she regarded Tufts as an outside intruder on her own belief in her status as part of Mound Bayou’s ruling elite” (Geiger correspondence 12/08). She would prove to be a continually disruptive force on the nursing staff. The hostility of the Earl and Mary Lee Lucas and their colleagues toward the project was so severe that when Willie Lucas, the mayor’s younger brother who was a high school teacher in Mound Bayou, was offered admission and scholarships to Tufts Medical School, they accused him of being a traitor for accepting (Geiger correspondence 12/08).

Another one of the earliest examples of the elites’ negative attitudes towards the Health Center occurred when Geiger and Hatch took an option on ten acres of land on the edge of Mound Bayou from a black landowner, Mr. Laythem, for the future site of the Center. As a goodwill gesture, Hatch gave the option to the Mound Bayou Development Corporation

(MBDC) to provide them with some business. The MBDC, who included some of the most well-off citizens of Mound Bayou, held the option on the land during the ensuing months. When a deal was finally made for constructing the new facility, the MBDC refused to turn the option back over to the Health Center unless they could own and control the Center. To solve the conflict, Hatch had the MBDC return the option to Mr. Laythem so they didn't have to suffer the embarrassment of giving the option directly to the Health Center staff. To Geiger, the situation was the first overt signal of type of the social and economic disruption caused by the Health Center. "When you empower the poor," he learned, "the people who are most threatened are... the middle class who have been exploiting the poor" (Geiger interview 10/08).

Mayor Lucas and his colleagues knew that, in addition to overcoming any economic and social threat, being in charge of the Health Center would offer them the chance to control "the Center's nearly 200 jobs and its million-plus dollar budget" (Geiger correspondence 3/09). Their attempts at control were relentless. When Geiger left Tufts in 1971 to head the Department of Community Medicine at SUNY Stony Brook, the Health Center's community board and OEO decided to move the grant to Stony Brook. However, this arrangement was quickly derailed (Geiger correspondence 3/09).

To follow this aspect of the Center's development, it is necessary to understand its earlier history: even before the Tufts-Delta Health Center had been fully established, Geiger and his colleagues realized that the Taborian and Sarah Brown hospitals were on the verge of bankruptcy. The Tufts project stepped in to provide extensive emergency relief that included adding Drs. Burton and Lowry to the Health Center payroll, and immediately going to the OEO to obtain a parallel OEO grant for the hospitals. In order to qualify for this grant, the Taborian and Sarah Brown hospitals were required to merge into a single community hospital, "open to all

poor patients—not just the insured members of the fraternal orders” (Geiger correspondence 3/09). They also had to establish a new representative governing board. Seizing the opportunity, Mound Bayou elites quickly took over the new board of the resulting OEO-funded “Mound Bayou Community Hospital” (Geiger correspondence 3/09).

When the Tufts grant was later being transferred to Stony Brook, Mayor Lucas and his fellow Mound Bayou political and social leaders made their next move, aggressively lobbying the OEO—in the agency’s “dying days” under the Nixon administration—to give them control over the Center (Lefkowitz, 2007; Geiger correspondence 3/09). Unaware that these protestors were not authentic or sympathetic representatives of the poor community, and that the overwhelming majority of Health Center patients were not from Mound Bayou but from all the other communities in the Bolivar County, the OEO conceded. They merged the Health Center with the Mound Bayou Community Hospital in 1972, “thus excluding Tufts and its successor, Stony Brook,” (Geiger correspondence 3/09). Some Tufts physicians stayed on for a little while, but the mayor’s family quickly took over all of the administrative positions. “They ran it into the ground,” said Geiger. “There were huge deficits, there was talk of embezzlement” (Geiger interview 11/08).

Aside from elites’ self-serving and misguided management, Geiger notes that there were three fundamental problems with the new leadership structure:

First, the new combined grant was to the new board—not an institution of higher education—and was no longer veto-proof; the Mississippi governor promptly vetoed it, and only with great difficulty was the grant finally approved. Second, by this time all the previously white county hospitals in the Delta area had to be open to black patients funded by Medicare and Medicaid Programs, and the need for a black hospital, as such,

was disappearing. Third, without a university or medical school sponsor, the merged entity lacked medical and other professional resources, and the quality problems that afflicted all small isolated hospitals intensified (Geiger correspondence 3/09).

Nevertheless, Lucas and his colleagues continued attempts to expand their power base, even after the OEO was terminated and its health grants transferred to the Department of Health, Education, and Welfare, by “launching a rather grandiose campaign for the construction of a new, 150-bed black hospital in Mound Bayou” (Geiger correspondence 3/09). With less than two dozen patients recorded in the Mound Bayou Community Hospital’s inpatient census, the campaign fell flat. Shortly thereafter, the State of Mississippi, “citing quality problems,” closed the hospital down (Geiger correspondence 3/09).

The Health Center remained under the control of local elites until the late 1980s when federal authorities visited Mound Bayou and threatened to shut down the entire operation unless a new governing board was formed. The board of the Health Center invited Dorsey to return as Executive Director. Having received her MA and PhD, Dorsey accepted their offer and returned to serve in this role from 1987 to 1995. She organized and modernized the Center, established satellites and home health services, and diversified its funding base (Lefkowitz, 2007). Despite her accomplishments, she was made to feel unwelcome by the patronage operation still in place at the Center. Dorsey’s tires were slashed and she received multiple death threats from people who would tell her: “Why don’t you go out the door, back into the cotton fields where you belong?” (Geiger interview 11/08). Mary Lee Lucas, the wife of Mayor Earl Lucas and the director of nursing at the Center, was the alleged “ringleader” of this opposition and harassment campaign (Geiger correspondence 12/08).

The resentment aimed at her, Dorsey believes, is rooted in the concept of “class” or “position”—often called “place” in the black community. “I was out of my place,” she said. Some of the wealthiest and most well-educated people in Mound Bayou recognized all that she had accomplished personally and professionally, and supported her. But, she says, speaking in the third person:

... there were other people who only remember that she [had originally come] off a plantation and that she lived in a house that had been condemned by the city and nobody was supposed to be living in. That’s how poor she was. That she didn’t have clothes, she didn’t have a car, she didn’t even have a house that was fit for her children to live in. And at that point your total worth of whatever you could do to help anybody else was compromised by what people knew about you (Dorsey interview 12/08).

Since resigning from the role of Executive Director in 1995, Dorsey has faced additional hurdles. When she ran for NAACP Field Director, she was turned down after being told that she “wasn’t middle class enough” (Dorsey interview 12/08). She faced the same kind of opposition when she ran for school board in the 75 percent-black town of Shelby, Mississippi, losing to a white man whose children were enrolled in private academies. To this day, she feels unwelcome on the grounds of the Health Center. Dorsey sees her lifelong struggles not a result solely “of *white* people’s racism,” but of opposition from blacks who “had grown up in the community where they really didn’t want anybody to have the sorts of opportunities that [elites] had” (Dorsey interview 12/08).

DISCUSSION

The Tufts-Delta Health Center succeeded in numerous ways that provide an instructional and inspiring example to inform current community health programs. For the local community, this comprehensive project offered many opportunities and benefits. Jobs, food, environmental improvements, and clinical services all contributed to improvements in physical, mental, social, and economic well-being. As my analysis of the empowerment domains demonstrates, individual and collective efficacy resulted from improved participation and leadership, enhanced abilities to define and evaluate problems, and increased resource mobilization.

From Hatch and Geiger's perspective, the most important long-term impact of the project was its provision of expanded educational opportunities for the poor offered through its numerous college preparatory courses, professional and paraprofessional trainings, field internships, and collaborations with local and national colleges and universities. Geiger notes that today more than 100 African Americans from Bolivar County are health professionals, "at levels from technician to physician." Geiger and Hatch also recently identified the first grandchild to earn a doctorate (in clinical psychology), who is now working in Jackson, Mississippi (Geiger correspondence 3/09, Hatch interview 8/08).

For health professionals, the Health Center offered lasting lessons about the need and viability of merging of public health and biomedicine in resource-poor settings, including an emergent focus on social determinants of health as key indicators and points of "upstream" intervention. For the community health center movement, the Tufts-Delta Health Center was a groundbreaking experiment and model to which others aspired. It foreshadowed the establishment of dozens, and later hundreds, of community health centers. Today, there are 1,200

community health centers in the United States, providing care to 18 million people, 1 in 5 of the population of low-income, uninsured Americans (NACHC.com).

The Tufts-Delta Health Center also faced many challenges and problems, exposing some of the unintentional and unanticipated outcomes of empowerment approaches. Opposition from the white political and medical power structures was something the Health Center planners expected and for which they were fairly well prepared. They primarily overcame this resistance through creative maneuvering, such as ensuring that the state did not have the power to veto OEO grants, and setting up the Health Center in an all-black town with limited interference from whites. Opposition from local black elites, who interacted more closely with the project, was much more intense and less anticipated by or familiar to the Health Center planners. By organizing, employing, and giving major advisory control to the poor, the Center represented a social and economic threat to elites.

Elite opposition and efforts to take control may have partially resulted from some of the project's struggles to achieve domains six and seven of Laverack's empowerment framework: "Links with other people and organizations" and "Equitable relationships with outside agents." In his discussion of these domains, Laverack notes that relationships with people and organizations outside the target population, ideally based on mutual interests, is "an important step towards empowerment and can also lead to an improvement in health outcomes by pooling limited resources and by taking collective action" (Laverack, 2006, para 28). Extending the argument beyond mutual interests, Flora Cornish and Riddhi Ghosh (2007) write that "collusion with powerful interests" is especially critical when "those interest groups have the power to put a stop to the project" (Cornish and Ghosh, p.498).

Had the Health Center been able to collaborate, collude, or co-exist more strategically from the outset with local black interest groups, like the Taborian and Sarah Brown hospitals, as well regional black institutions, like Meharry Medical College, it may have prevented some of the class and racial conflict that hurt its reputation and widened the opening for elite cooptation. The same principle applies to some white institutions, whose feeling of exclusion from the project may have increased their resentment and efforts to dismantle the project. And these questions are not only contemporary ones. As a writer for the magazine *Science* asked in a 1967 profile of the project:

Could the project's apparent isolation from Mississippi's white medical establishment have been avoided? Might it have been possible, for instance, to have had the University of Mississippi Medical Center, at Jackson, collaborate with Tufts in running the Delta Health Agency? No definite answer is possible, for, although the delta project has been discussed with the university, neither Tufts nor OEO has suggested or contemplated that University Medical Center might share in the project management (Carter, 1967, p.1467)

However, as this paper's *Resource Mobilization* section showed, it is clear that the Health Center, and particularly the Co-op, emerged from and cultivated a number of important partnerships—from land and equipment loaning to shared agricultural innovations—that improved the visibility and reputation of the project. By addressing certain issues in a way that incentivized elite cooperation, such as the Health Council's success in reforming racist bank regulations by awarding them the project's accounts, the project achieved its own goals and set lasting precedents.

This issue of relationships and partnerships points to a larger question of how the concept of *community* is fundamentally understood in a project of this type and scope. Irene Guijt and

Meera Kaul Shah (1998) note that many empowerment programs are “flawed” because they “do not deal well with the complexity of community differences,” including class (p.1). Morgan (2001) adds that by treating community as a homogenous or fixed entity, a program can end up “reinforcing or undermining existing identities within stratified socioeconomic contexts” (p.226). Cornish and Ghosh make a similar argument, noting that in cases where the community is uniformly conceptualized, more often than not the “groups who wield greatest power...continue to dominate” (p.497). This is particularly true in communities like Mound Bayou where the poor residents’ existing relationships with elites was “exploitative and conflictual rather than trusting or supportive” (p.498). By offering social services, organizational structures, and leadership roles to a segment of the community it intended to empower, the Health Center project isolated elites, inadvertently provoking them to attempt to leverage new resources and power.

The challenges and opposition faced by the Mound Bayou project offers some important take-home lessons. First, empowerment is not a zero-sum goal. The positive impact of the Health Center on poor, powerless individuals in rural Mississippi, as well as the outgrowth of hundreds of health centers in underserved communities thereafter, illustrates “the successes that imperfectly participatory projects can achieve” (Cornish and Ghosh, 2007, p.497). Rifkin (1996) adds that community participation has been conceived as “a magic bullet” for extending power to the marginalized, thus framing power struggles as destructive (p.79). Instead, power struggles should be seen as a normal and healthy part of any health or community development program, and planners should allocate ample time and resources towards working through these issues. Second, realistic goal setting is an important step toward effective and sustainable programming. The expectation that a project of the Tufts-Delta Health Center’s scale will break down cycles of entrenched inequity and patronage is unrealistic. Therefore, reasonable goals and expectations

for the extent to which participation can be achieved, as well as the subsequent impact of participation and empowerment on preexisting social hierarchies, should be taken into account. Third, members of communities should not be assumed to be similar or equal to one another. Doing so can unintentionally allow economic or social elites to take advantage of opportunities for participation, or obstruct vulnerable groups from doing so, in order to maintain power and control. Instead, defining and involving a community based on interdependencies “in which their actions have effects on each other” can enable collusion with powerful interest groups that is both “compatible” with most health and empowerment goals and “necessary” to ensuring the survival of many programs (Cornish and Ghosh, 2007, p.498).

CONCLUSIONS

The Tufts-Delta Health Center was the forerunner of a movement that changed the way we think about health and health care. It furthered national awareness of the failure of traditional health systems to reach marginalized populations, and showed the effectiveness of bridging public health and clinical interventions at a grassroots level. It demonstrated why race, class, and power are important determinants of health, and why community is a critical locus for health care delivery and social change. Rather than pathologize poor people, it highlighted their assets, strengths, and ways of knowing, and prioritized their active involvement. The project not only managed to initiate an empowerment-based and comprehensive approach to health care, but it did so in the context of some of the most entrenched race, class, and status segregation in the country.

It also set a remarkable precedent. From rural Mississippi to urban Massachusetts, the 1,200 urban and rural community health centers operating today in the United States are an integral safety net, providing care for 1 in 8 uninsured Americans and 1 in 5 low income uninsured (Proser, 2004). The poor, racial and ethnic minorities, and uninsured people who most depend on health centers are the “populations who face the greatest barriers to quality health care” in the U.S. Health center care breaks down these barriers by achieving dramatic improvements in the use of preventative services, management of chronic diseases, and overall health status. One of the most striking impacts is seen on low birth weight, a condition that disproportionately affects African Americans and is a primary correlate of infant death. African American women who receive care at health centers deliver low birth weight babies at 20 percent below the national rate for African Americans, despite the fact that the women the health

centers serve are poorest, least educated, and most ‘at risk’ of all mothers. From dental services to diabetes, other indicators of prevention and treatment demonstrate comparable success (Poltzer et al, 2003).

Many of the strides community health centers have made to close these gaps are attributed to the high-quality, comprehensive, culturally-sensitive care they deliver. Health centers are also praised as a cost-effective approach that avoids the need for expensive hospital emergency or specialty care. On average, total medical cost per patient per year is \$250 *less* than the cost of a care at a private primary care practice (Proser, 2004). Patient satisfaction is extremely high, with 96 percent of surveyed health center patients reporting that they are satisfied or very satisfied with the care they receive (Poltzer et al, 2003).

There is no question that the model *works*. Still, it struggles to survive. As community health centers have become more institutionalized and tried to keep pace with a complex, technically-oriented medical marketplace, they are facing a breadth of new challenges. Many changes in the health care environment over the past 15 years—including shifts in reimbursement structures, managed care delivery systems for Medicaid, greater numbers of uninsured and underinsured, and state budget shortfalls—have put health centers under financial and organizational stress (Taylor, 2004). These stresses put a burden on already overstretched health center personnel to acquire additional skills and capacity. “Daily life is a constant struggle with the bottom line,” writes Bonnie Lefkowitz, “and conference schedules are crowded with management techniques, financing strategies, and sales pitches” (Lefkowitz, 2007, p.135).

Many centers struggle to maintain an effective participatory leadership structure in the face of increasing economic and governance challenges. Anthony Schlaff, director of the masters in public health program at Tufts Medical School who has worked with community health

centers throughout his medical career, believes that internal dynamics of participation within the health center leadership are often equally if not more disruptive than the financial and managerial burdens of a rapidly changing medical marketplace. Schlaff explains that the triumvirate of health center governance—board, executive director, and medical director—are ideally like branches of government, in which no single branch can exert full control. In reality, competing loyalties, anti-professional attitudes, and political interests disrupt this balance (Schlaff interview 2/09).

For example, executive directors have had to adopt the mindset of business people, not community organizers. In some cases, this new orientation has led them to use the health center as a base for political power and personal gain. Medical directors are in a tenuous position of feeling that they have to represent the interests and needs of the physicians who work at the health center and defend against anti-professional bias. And despite federal grant requirements that 51 percent of boards members must be patients at the health center, many boards fail to be truly representative of the health center's patients, but are comprised of wealthier and more prominent members of a community. Schlaff explains that “boards are at best a potential stopgap against the total domination by a business or professional model” —and ultimately not even that if the executive director handpicks the board, as is often the case (Schlaff interview 2/09)

From Medicaid and managed care to politics and paychecks, health centers are constantly encountering and adapting to new pressures. With some notable exceptions, including Codman Square, “Community health centers have, to a great extent, moved much closer to the mainstream,” says Geiger. Most have scaled back their public health and community development roles substantially, focusing on a more limited medical model rather than the preventative, outreach, and educational offerings that began in Mound Bayou. However, this

pattern of increased bureaucratization must also be understood an expected outcome of a movement that grew from a radical grassroots experiment in 1965 to a national and diverse network of over 1,000 centers in 2009. Such evolution “is probably inevitable as a system institutionalizes, until we get the next, hopefully more radical institutional change,” says Geiger (Geiger interview 11/08).

What would it take to renew community health centers’ commitment to comprehensive services and effective community-based leadership? Looking back at the story of Mound Bayou, and scanning ahead to the experiences of Freeman and Walczak in Dorchester and Boston, we can glean several important insights. The first is leadership. Today, health centers are much less dependent on direct federal grants than they once were, and the largest portion of their revenue comes from Medicaid. Accompanying this change in funding is the change in the professionalization of leadership that Schlaff described. These days, Geiger explained, there seemed to be “only two types of health center leaders”: the clinicians who are involved in improving health care quality and delivery, and the executive directors who are concerned about funding streams, productivity, and information technology. That is a huge change from “the salad days of OEO,” as Geiger puts it, when the most complex economic strategies required he and his colleagues order backhoes and creatively squeeze them in the capital equipment budget (Geiger interview 11/08).

As the authority and direction provided by community members and organizers gives way to more bureaucratic voices, opportunities for community empowerment and broader social change are becoming scarce. Schlaff believes that greater federal licensing and funding, much in the way OEO grants were administered in the 1960s and 70s, could promote more community-responsive leadership among executive and medical directors, and more representative

membership on boards (Schlaff interview 2/09). Another critical step towards strengthening health centers' leadership is expanding opportunities to recruit, train, and support a diverse healthcare workforce. In an era when minorities make up one-quarter of the entire population yet only 11 percent of medical school classes, programs like the National Health Service Corps are needed more than ever to eliminate educational or professional disparities and the health disparities they exacerbate (Hawkins and Rosenbaum, 2005).

While community health centers must be cautious of “selling out” to the mainstream health care system to preserve the community focus and participation that made the original model so groundbreaking, the benefits of these changes must also be examined. Namely, it is unlikely the health centers could have survived without adapting to certain aspects of contemporary health business and bureaucracy. The model is probably far more sustainable today than in its initial design. When Tufts-Delta Health Center and its peer centers of the 1960s were established, they were primarily conceptualized by pioneers and politicians alike in terms of “experiments” or “demonstration projects.” In many cases they were “strictly seen as a stopgap, so to speak, to provide care to poor people when others wouldn’t provide it,” says public health pioneer and Distinguished University Professor of Social Medicine at Montefiore Medical Center and Albert Einstein College of Medicine, Dr. Victor Sidel (Sidel interview 8/08). Most planning was geared for the short-term; some of the tensions and eventual cooptation that arose in Mound Bayou reflected this approach. As they look to make community health centers survive and grow into the future, leaders need to find ways to remain true to the grassroots vision of equity while balancing the demands of a competitive, market-based system. One of the reasons that Codman Square Community Health Center is so successful in this respect, says Schlaff, is because Bill Walczak, its original executive director, has “become a businessman

because he had to, but [remains] intrinsically a community organizer” (Schlaff interview 2/09). Straddling both spheres requires knowledge, training, and support that regional and national organizations like the Massachusetts League of Community Health Centers or National Association of Health Centers are in a key position to provide.

The future success of community health centers may also depend on fundamental changes in the culture of medicine that would make the health center a more sought-after environment to develop one’s professional career. To have physicians emerge from a minimum of seven years of training and socialization and be enthusiastic about community oversight of their professional realm would require no less than “a revolution in the culture of medicine,” says Schlaff (Schlaff interview 2/09). Other aspects of the health center model—including the team-based practice of medicine; a focus on holistic, preventative, and primary care; and a minimized focus on specialty care—contradict many pillars of the current medical model and compensation structure. During the early health center years, the National Health Service Corps (NHSC), which provided loan repayment and scholarships in return for a commitment to practice full time in a medically-underserved area, was a major source of health personnel at the centers. However, dramatic reductions in NHSC members in the 1990s made it extremely hard for health centers to meet staffing needs and earn revenue (Plaska and Vieth, 1995).

The moral imperative for medical school graduate has also faded. Few young professionals are like Dr. Jack Geiger and were community organizers for a decade before going to medical school. Therefore, recruiting and retaining them at community health centers remains a major challenge. The National Association of Community Health Centers is even considering starting its own medical school in Arizona to address this gap. Health centers are less of a focus of student interest and activism than they were in the 1960s, when the Student Health

Organization and Medical Committee for Human Rights were infused with the energy and urgency of the civil rights movement. Geiger estimates that some of the interest has also been diluted by the increasing popularity of involvement in international health projects for undergraduate and graduate students alike. “This phenomenon has, in some ways, operated to the detriment of problems [domestically],” he says (Geiger interview 11/08). Through a renewed focus on domestic public health and community oriented primary care, beginning in medical school and even college, health centers could strengthen their professional ranks and reputation.

Part of this change requires overcoming the false sense of *threat* that many people still associate with health centers. Harkening back to organized medicine’s vehement opposition to settlement houses and dispensaries in the 19th and early-20th centuries, Schlaff recalls the challenges he faced as a community health center physician, as late as the 1970s and 80s, to get admitting privileges at academic medical centers. There was a prevalent sense that care at health centers is a disruption to the practice and profession of medicine. Things have improved quite a bit since then, but this ambivalence still exists today. He explains that there is a sense of superiority among physicians at mainstream academic medical centers that:

once you’ve gone through the socialization process and emerged into the medical priesthood, going into these community settings is going over to the dark side. It exists apart from class. It’s a kind of art - but you’ll see in a medical record: “the patient was sent in by an IMD,” obviously [referring to an] incompetent doctor. “Therefore we need to rescue [the patient].” I think there’s a class phenomenon, but also a primary care versus specialty, and community versus academic (Schlaff interview 2/09).

Even when he gained admitting privileges at a major New York City teaching hospital, both Schlaff and his patients were treated like second-class citizens. When he asked specialists to

examine his patients, they would refuse. “It clearly felt to me it was because these patients to them were a burden or an obligation imposed on them by the hospital, but this wasn’t their livelihood” (Schlaff interview 2/09).

Physician opposition isn’t the only paradox that evokes memories of the past. Many working class communities which would benefit tremendously from health center services (and jobs) today are swayed by negative stereotypes. Edna Smith, a longtime nurse-activist and community health center founder and advocate, is puzzled by this resistance in a town like Framingham, Massachusetts. “People out here don’t want a health center,” she says. “They don’t think they need it.” At town hall meetings and community events, many residents complain that social services including health centers are “what’s bringing in the immigrant population and [other] ‘undesirables.’” From her research and clinical work, Smith knows that the populations of homeless and substance users are on the rise in Framingham (E. Smith interview 7/08). Solutions to these “taboo” problems, including addressing the social and economic needs of new immigrants, are met with skepticism. Widespread 19th century middle-class myths and fears—that hospitals would promote immortality, irresponsibility, and laziness by attracting the poor and homeless to their communities—are surviving well into the 21st century.

In 1965, a few idealistic physicians and community organizers began an experiment and embarked on a journey, redefining our national understanding of what it means to be healthy. They took risks, made mistakes, and ultimately demonstrated that quality, community-based health care for the most poor and marginalized is not just a goal, but a national responsibility; it is not just a way to improve health, but to redistribute power and fight poverty. Nearly forty-five years later, the moment has arrived to reclaim that blueprint. In 2009, America’s economy is in decline and unemployment is rising; fewer people can pay medical bills; medical debt is the

leading cause of personal bankruptcy; and the number of uninsured grows. As national wealth and health diminishes, the nation's first black president has made accessible and affordable health coverage a key priority. In a time of ambitious goals and fiscal constraints, strengthening and expanding the health center network offers a way to balance health care costs, access, and quality, and to catalyze major social, political, and economic improvements.

And that's history worth repeating.

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