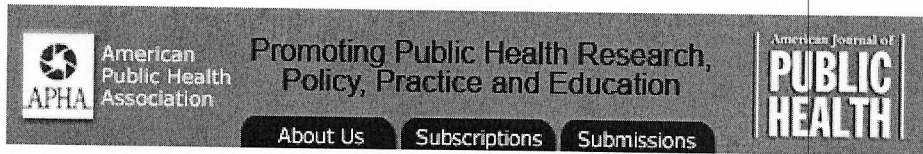


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The First Community Health Center in Mississippi: Communities Empowering Themselves

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The premise of a successful community health center is the active involvement with its target populations in ways that will change their knowledge, attitudes, and motivation—address the social, economic, environmental, and political circumstances that determine their ill health. To say these things and stop there is simple rhetoric. To act on them, to give them expression in new programs and new social institutions, to make them at once a part of the experience of the oppressed and the knowledge of the health professional student, requires more. Yet it can be done. The story of what began as the Tufts-Delta Health Center is a case in point.

THE TUFTS-DELTA HEALTH CENTER

The Tufts Comprehensive Community Health Action Program, of which the Tufts-Delta Health Center was a component, was first proposed in 1965 to intervene in the cycle of extreme poverty, ill health, unemployment, and illiteracy by providing preventive, curative, and health education programs, while organizing community health associations.

In the 60s there was no recent American history of attempts, conceptually or in practice, to see and use community health services for the poor—not merely as an assault on the specific health problems and health care needs of the poverty population but also as a basis for community organization and development—and, through community organization, for the implementation of social change in access to food, housing, clothing, water and sanitation, jobs and economic development, education and educational opportunity, and mobility and transportation services. Isolated from the sources of technical and economic assistance, these communities were struggling with early and overwhelming deprivation of children, and individual, family, and community fragmentation. While the idea of intervention in the poverty cycle was current at the time, the thought that health services might be a point of entry for broad social intervention was relatively new.

UNCEASING STRUGGLE AGAINST DISASTER

In Bolivar County, Mississippi, around 1965, Black people in poverty, particularly the isolated, rural, Black ex-sharecroppers and ex-plantation workers who constituted the vast and silent majority of the Black community, lived in an unceasing, and often losing, struggle against disaster. They were hungry; there was no food. They were unemployed; their skills had been made obsolete by the mechanical cotton picker, the herbicide-spraying crop duster, and the ironies of cotton and other national crop-subsidy, acreage-restriction policies. The median annual family income was \$900. They lived in crumbling, patchwork shacks with leaking roofs, rotting floors, buckling walls, gaping windows, newspapers for insulation, and crude stoves for heating and cooking—when there was firewood. Many drank contaminated water from drainage ditches and used dilapidated surface privies for personal sanitation. Infants under such circumstances often ingested their own excrement; children lacked the shoes to walk to school, the clothes to wear to school, or given these, the food to sustain learning. Adults, particularly the stronger men, migrated north to the urban ghettos in search of work, fragmenting families and leaving the elderly isolated and alone. For the rural Black community, basic institutions (such as the Black church) struggled to survive. In the midst of national affluence, for this population hope was a luxury. Survival was the primary occupation.

ACTIVE COMMUNITY INSTITUTIONS

Community organization at the Tufts-Delta Health Center began in 1966. Training activities began in early 1967 in an abandoned movie theater. Clinical health services began in late 1967 in a remodeled church parsonage. The combined programs of the health center, the local health associations, the health council, and the farm cooperative touched on every major problem area affecting the lives and the health of the rural poor. Programs alone, however, could merely be palliative; the only hope of their long-term survival and long-range effects lay in rooting them in viable, effective, community-based institutions. Thus, even more important than the programs and health and community services was the development of a series of flourishing, active, and effective community institutions. These included 10 local community health associations, each with its own community center and its own programs linked with the health center; the North Bolivar County Health Council, representing all the local communities, developing programs for them and for the entire area, operating significant components of the health center program, and ultimately serving as the owner, the policymaking and controlling consumer body, and the operator of the health center; the health center itself, a modern, 30 000-square-foot facility employing more than 200 people (most of them from the area's own population) on what was previously a cotton field; and the North Bolivar County Farm Cooperative, related to but entirely independent of the health center and health council, while producing thousands of tons of vegetables to be distributed to its worker-members.

These institutions served the community, and they were staffed by the community: every Black household in the poverty population in all of northern Bolivar County had at least one (and often more than one) adult member actively participating in decision-making, program planning, and program operation through a local health association. Each month, the various divisions of the health center accumulated a total of more than 6000 patient or resident encounters.

INTERVENTION, PROGRAMS, AND SERVICES

The Tufts-Delta Health Center was designed as a base for multiple points of entry into the problems of health and poverty. There were comprehensive health services providing integrated ambulatory and hospital care; preventive and curative medicine in pediatrics, adult medicine, obstetrics-gynecology,

and surgery, with participation of social work, group work, nutrition, health education, and community organization workers recruited and trained from the community itself; environmental services (e.g., safe water, minimal sanitation); and nutrition, including growing and processing food.

Community organizer John Hatch ([Figure 1](#)), in his own frequent publications on his work at the health center, has emphasized the extent to which a new world of broader hopes and expectations was opened up for young Black people in North Bolivar County by the health center's efforts to provide educational and training programs ranging from high school equivalency to precollege and preprofessional courses taught by the center's own professional staff. Then the health center worked to find or create pathways to cooperating colleges, universities, and professional schools across the country to help make such hopes a reality. These efforts produced Black physicians, nurses, dentists, social workers, psychologists, engineers, and administrative managers, most now working in the health sector in Mississippi and other southern states.



H. Jack Geiger (left) and John Hatch (right) during the construction of the Tufts-Delta Health Center, Bolivar County, Mississippi, in 1966. Photo courtesy of Dan Bernstein. Printed with permission.

Together with Medicare, Medicaid, food stamps, and other programs, the health center's work improved the health status of its roughly 12 000 Black residents of North Bolivar County. Incidences of fetal losses, infant mortality rates, infectious disease, and chronic illnesses such as heart disease, hypertension, and diabetes all went down. In significant measure, these gains were also a consequence of the passage of the Civil Rights Act of 1964 and the Voting Rights Act of 1965.

THE COMMUNITY HEALTH CENTERS' BIG BANG: 50 YEARS OF GROWTH

When the Tufts-Delta Health Center and its urban twin, the Tufts-Columbia Point Health Center, were first proposed to the Office of Economic Opportunity, there were few, if any, comprehensive neighborhood health centers in the United States. The poverty program included no explicit health components; the disastrous health states and desperate health care needs of the poor were just beginning to be recognized as problems of a magnitude requiring new and unique approaches. Today, more than 1300 community health centers have been created in the United States, both rural and urban. They also serve migrant farm workers, public housing residents, and students at public high schools. They deliver primary care at more than 9000 sites of clinical service, serving more than 25 million low-income and minority patients. This phenomenal growth over a half-century reflects the participation and commitment of literally hundreds of thousands of health professionals and community residents alike. For many of those physicians, dentists, and others, their work in community health centers became a lifetime career, embodying the impulses that brought them to health care training in the first place. Equally important in this growth was the role of community residents and whole communities in creating their own community health centers and moving on to assume ownership and operating responsibilities. Under current guidelines, every federally qualified community health center must be a nonprofit corporation, with 51% of its board of directors drawn from current patients of the program. There is no other part of the American health care system in which patients themselves have such a powerful voice. Perhaps the most significant fact about what began as the Tufts-Delta Health Center is that for almost 40 years it has been owned and operated by the North Bolivar County Health and Civic Improvement Association, the community organization of poor people and poor communities that the health center helped to create.

These new models of care have also varied widely from each other and, over time, in the degree to which they have successfully intervened in population health status. In recent decades, as a consequence of federal funding cuts and conservative congressional ideologies, many health centers have had to restrict their efforts to the more limited provision of individual personal medical care, while abandoning broader attempts at intervention to address the root causes that help produce those illnesses. As our national health care system continues to evolve, I believe it is time for community health centers to return to those early initial models that saw health care as an instrument of social change—partnering with communities to confront the social, economic, environmental, and political circumstances that so powerfully shape the population health status of the disadvantaged and marginalized. Access to good clinical primary care should remain their central contribution, but their task is incomplete without this broader social effort.

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