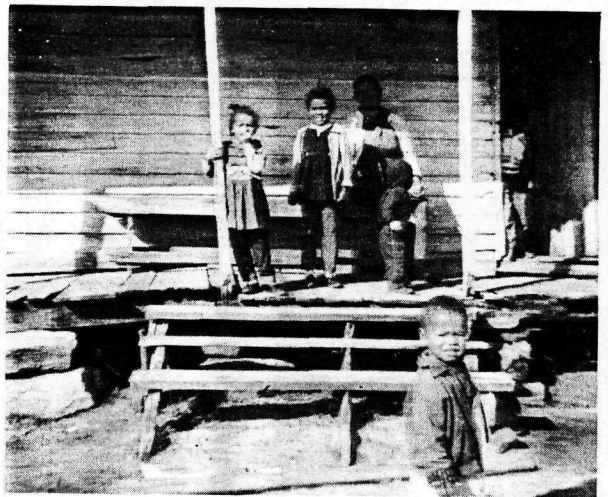
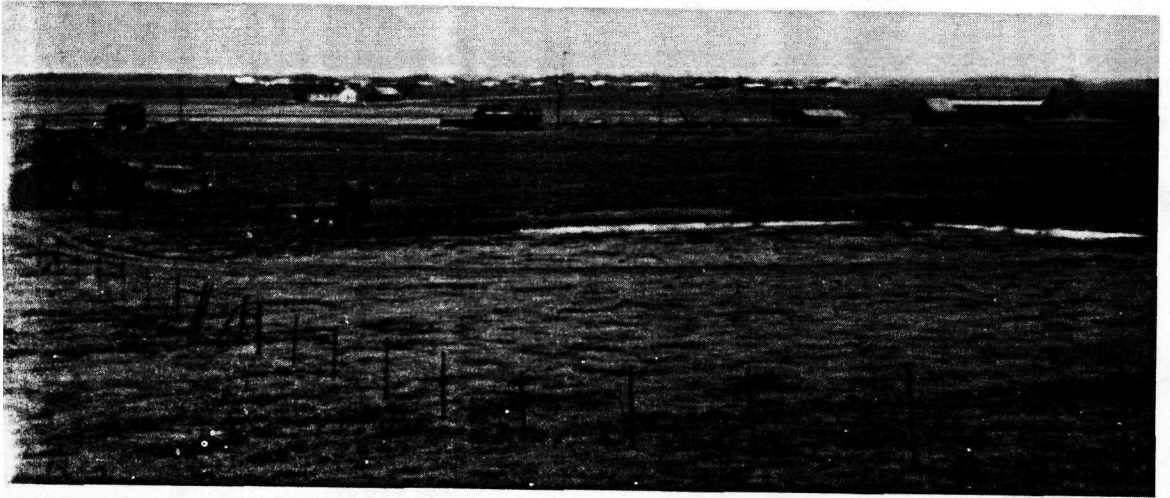


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TUETS PREVENTIVE MEDICINE EXTENDS TO MISSISSIPPI

Delta Cotton Fields and Housing Problems in or Near Mound Bayou

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TUFTS IN MISSISSIPPI—THE DELTA HEALTH CENTER

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The Tufts Department of Preventive Medicine—which has already pioneered in the development of a neighborhood health center at Columbia Point, Boston, Mass., and served as the model for a planned national health program based on a network of urban health centers for poverty populations—is planning another pioneering step: the development of a rural health center in the Delta area of Mississippi.

HEALTH CENTER AT COLUMBIA POINT

Just as the Tufts Comprehensive Community Health Action Program represented a totally new approach to the health problems of the urban poor—and an attempt to use health services to intervene in the “poverty cycle” of low income, low education, unemployability, ill health, social isolation and withdrawal, and community disorganization—so will this new venture be the first attempt to intervene in the health-and-poverty problems of a rural area, under university and medical school auspices, as part of the poverty program.

As readers of the November, 1965 issue of the Tufts Medical Alumni Bulletin know, the Columbia Point Health Center—a direct teaching, research and service branch of the Department of Preventive Medicine—brings together under one roof the complete spectrum of facilities and personnel needed for comprehensive, family-centered, high-quality ambulatory care of the poor: internists and pediatricians and other specialists, community health nurses, social workers, health educators, physical therapists, laboratory technicians, pharmacists and others; physicians’ examining and consulting rooms, a fully-equipped emergency room, a complete laboratory, a pharmacy and x-ray and other ancillary facilities. And this health center is in the community it serves, and linked to it in a series of ways: first, in partnership with the Columbia Point Health Association, representing the community itself; secondly,

through the employment of local residents as secretaries, nurse’s aides, technicians and in other roles; thirdly, as a base for community organization and health education; and lastly as a center for the training of local residents as home health aides, family health aides, nurse’s aides, community development workers and other health careers.

This enormous venture has, so far, been a resounding success—not only in the provision of health services to the 6,000 residents of the Columbia Point Housing Development and in the beginning of urgently needed medical care and social research, but also as a model for the Office of Economic Opportunity’s (Poverty Program) planning and funding of other urban health centers in New York, Chicago, Denver, Los Angeles, and other northern cities with high concentrations of “central-city” impoverished populations with high health and social needs.

With all this under our belts—and much more still to be done in Boston—why Mississippi?

A SOUTHERN RURAL HEALTH CENTER

A southern rural health center has been planned from the very beginning of the initial \$1,168,000 O. E. O. grant for the Comprehensive Community Health Action Program. From the very beginning, it has been Tufts’ belief that there are at least **two** major identifiable populations that represent perhaps the poorest—and sickest—groups in the United States, and which should be a focus of outreach from the medical schools. The first is the population of the northern central-city areas, the ghettos and blighted neighborhoods of the north; the second is the population of the rural south, particularly the Negro population. Indeed, these two groups are linked by the massive northward migration of southern Negroes, one of the great social and population movements in the U. S. since World War II.

And so, for more than a year, faculty and staff of the Tufts Comprehensive Community Health Action Program have been traveling widely through the south—in Georgia, Tennessee, Arkansas, Mississippi, Alabama and other states—making field trips to possible site locations, reviewing medical and public health data, and meeting with local leaders and state officials in the search for a suitable site.

That site has now been found: Bolivar County, in the Delta area of Mississippi—one of the nation's richest cotton-plantation areas, but one of the nation's poorest in terms of the incomes and life circumstances of its rural Negro population. A specific "home base" for the health center, to be called the "Tufts-Delta Health Center," has been identified in the community of Mound Bayou, Mississippi.

The health challenges posed by poverty in a broad area of the southeastern and south-central U. S. are exemplified by figures from Mississippi.

SOME MISSISSIPPI STATISTICS

Of Mississippi's 2.2 million population, 58% is white and 42% Negro; 55% of the white population and 70% of the Negro population is rural. Poverty is the single most impressive fact, and it is skewed along



Old housing in Mound Bayou

both racial and urban-rural axes: in 1960, the mean family income of whites was \$2,023 (\$2,622 in urban areas, \$1,065 in rural areas) and that of Negroes was only \$606 (\$871 urban and \$471 rural). Education is similarly maldistributed; among those aged 25 and over, whites have a mean of 11 years' schooling, Negroes 6 years. It is in this context that health indices must be examined. In 1961, the maternal mortality rate for whites was 2.5 per 10,000 live births (identical with the rate for whites in the U. S. as a whole); the corresponding Mississippi Negro rate was 15.3, slightly more than six times as high, while the national rate for U. S. Negroes was 10.1. The infant mortality rate for Mississippi whites was 23.6 per 1,000 live births—slightly better than the national white rate of 25.3; the Mississippi Negro rate was 49.9, more than twice as high, while the national Negro rate was 40.7 per 1,000.

Clearly, the relationships are not simple. While Mississippi whites are poor, relative to the national average, this is not reflected in these health indices. At the extremes of poverty, however, Negroes—perhaps representing a special and particularly intense problem within the general problem of deprivation—show significant and serious health impairment.

The same is true of medical care utilization and facilities. In 1962, 97% of white births in the U. S. took place in a hospital and were attended by a physician; in Mississippi, despite the relative poverty and the predominantly rural distribution of the white population, the corresponding figure was 99.3%. Of Mississippi Negro births, however, only 53% were in a hospital and attended by a physician; 2% were attended by a physician in the home, and 45% were "other"—births at home attended only by a midwife, a nurse, or without professional assistance of any sort.

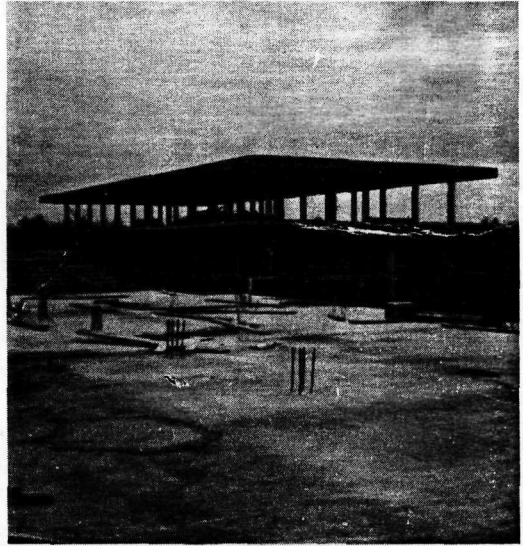
Poverty and rurality presumably are related to the state's shortage of physicians. In 1960, there were 77 physicians per 100,000 population, compared with a national average of 142. Of the 1470 registered phy-

sicians, 1411 were white and 59 Negro (and there has since been further substantial attrition in the number of Negro physicians). In the same year, there were 428 white dentists (19.4 per 100,000 population) and 37 Negroes (1.7 per 100,000); there were 4,068 white registered nurses and 376 Negroes. The distribution of physicians and of hospital beds, in Mississippi as elsewhere, is disproportionately urban; the majority of physicians are in general practice, and the predominant pattern is fee-for-service solo practice. Hospital facilities have been, almost without exception, segregated and unequal both in quality and in relation to the racial composition of the population.

In 1960, the average unemployment rate for Mississippi Negroes was 7.1%, more than 50% higher than the white rate of 4.5%. Of those Negroes unemployed, not more than 8% can be categorized as skilled workers, 31.9% were non-agricultural laborers and 21.5% were farm laborers. Thus, over 50% of the unemployed Negroes were unskilled laborers. Of the approximately 500,000 employed Negroes in the state, more than a third were employed in agriculture and another third in service industries. Although Negroes comprise almost 40% of the total labor force, only 4½% are employed in manufacturing. These figures hold despite a large continuing emigration of Negroes (many to the urban north).

Housing provides a final component of the poverty cycle. Of the 207,611 Mississippi Negro housing units listed in the 1960 U. S. census, only one-third were classified as sound; the remainder were classified either as dilapidated or deteriorating. Of the homes in rural areas, more than 75% were without any piped water at all and over 90% of these rural homes had no flush toilets, no bathtub and no shower.

The Mississippi figures merely illustrate problems that are general to almost all the areas in the "black belt" that extends from South Carolina and Georgia westward to Arkansas. In South Carolina in 1961, the white infant mortality rate was 22.8 per 1,000 live births; the Negro rate was 46.0.



The J. P. Campbell College—
Possible Health Center Site

In narrower focus, some of the figures are staggering. In McCormick County, for example, the white infant death rate was 20.8 per 1,000 live births, the Negro rate 107.3—in other words, every tenth Negro baby died in the first year of life. Other South Carolina figures follow the previously described pattern; e.g., of 34,505 white births, only 87 were attended by midwives; of 25,201 Negro births, 7,160 were attended by midwives.

BOLIVAR COUNTY

Bolivar County lies in the heart of the Mississippi Delta, along the Mississippi River in the northwestern section of the state. It is one of Mississippi's major cotton-plantation areas, and one in which the almost total mechanization of the plantations has produced an overwhelming shift from sharecropping to day labor—and greatly reduced employment even as day laborers.

The county's estimated population in 1964 was 58,430; the population is 65.7% Negro and 81.3% rural. An estimated 45.2% are employed in agriculture. The median annual family income in 1960 was \$4,420 for whites and \$1,108 for non-whites; the

median annual family income for rural Negroes was estimated at under \$900, or less than \$3.00 per day per family. The median age of the population is 18.3 years; median years of school completed is 10.8 for whites and 4.7 for Negroes.

There is significant outward migration; between 1950 and 1960 the Negro population decreased by 14.4%. In addition, there is migration within the county, from rural areas (as traditional sharecropping relationships disappear) to small towns and cities in the Delta. A recent Labor Department special survey of the Delta (including Bolivar County) estimated unemployment in the Negro work force at more than 60%. While direct migration data are not readily available, the 1960 census figures and comparisons with earlier census data indicate that migration is selective, by age and sex, leaving in Bolivar County a skewed Negro population with striking under-representation of young and middle-aged men in the productive years, some decline in the proportion of young women, and an excess of children and older residents.

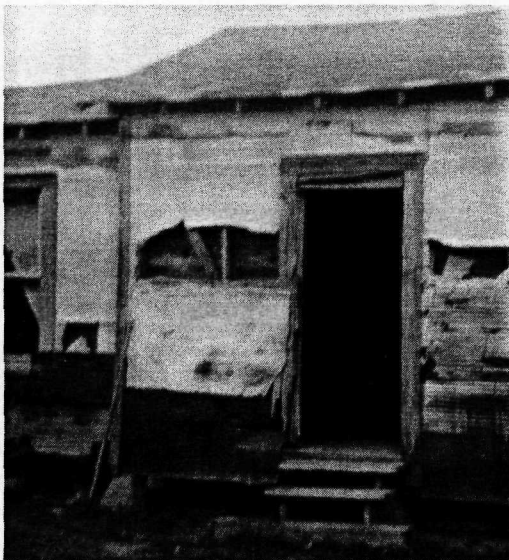
In Bolivar County, the infant mortality rate in 1964 was 17.1 per 1,000 livebirths



H. Jack Geiger, M.D.

for whites—a figure substantially better than the national average for whites—and 56.2 per 1,000 livebirths for Negroes. This represents a 33% decline in white infant mortality over the preceding four years—and a 25% increase in the Negro rate. The figures for attendance at birth follow the statewide pattern; only 7 of 351 white births in Bolivar County in 1964 occurred without a physician in attendance, but 643 of 1,422 Negro births—more than 45%—occurred without benefit of a physician.

For the County's 58,000 residents, there were 17 white and three Negro physicians in active practice in 1965; this is a ratio of 34.5 physicians per 100,000 population. Of the active white physicians, 10 are in the county seat, Cleveland, outside the proposed intensive service area in the northern half of the county; in the intensive service area itself there are only three white physicians, all in the town of Shelby. Of the three active Negro physicians, one is in Cleveland and two are in Mound Bayou itself; while each of the Mound Bayou physicians is primarily involved with the two small hospitals in Mound Bayou, both conduct some private practice.



Some Delta housing problems

Of the two small all-Negro hospitals in Mound Bayou, the Taborian Hospital has approximately 40 beds and the Sara Brown Hospital has approximately 24 beds. Both facilities are understaffed and in serious financial difficulty. In addition, there is a modern county hospital in Cleveland, and a small number of proprietary, non-accredited "clinics" or hospitals is located in Rosedale, Shelby and Shaw. Mississippi has no municipal or county charity hospitals; there are two state hospitals for the poor, of which the nearest is in Vicksburg, more than 100 miles away. Bolivar County Negroes are frequently referred to this facility.

The county has one of Mississippi's more active local health departments, with a county headquarters in Cleveland and a number of small two-room satellite clinics, operated on a part-time basis, in other areas of the county. The county and state health departments both report financial and staffing shortages; without their efforts, the infant and maternal mortality figures and other health indices would undoubtedly be even worse than they are.

Just as there are many reasons for need—economic, environmental and educational—so there are many kinds of barriers to adequate care: lack of health resources, lack of

funds, lack of transport, lack of knowledge, social isolation and discrimination. These are made clear not by statistical review but by field investigation. In all of the southern rural Negro areas investigated, a similar pattern was found; (a) most poor Negro families (those with less than \$1,000 annual family income) had difficulty in securing medical services without the intervention of a "substantial" person willing to stand for the bill; (b) those without positive contact with "substantial" persons usually went without care; (c) in many cases a non-medical person, often the boss or overseer, would assess the sick person's need for medical care; (d) one-fourth to one-third of the persons contacted in the rural Negro share-cropping population had **never** seen a physician.

CASE REPORTS

In the course of our exploratory work, a senior Negro member of the Tufts staff has traveled extensively in Bolivar County, working as a cotton-picker and field hand on the plantations, living in Negro slum housing in the small towns, and talking with individuals and social groups of all sorts. The following illustrative cases are typical of many in his experience:

"Case 1. Miss Jessie Mae and family.

A mother and 11 children, ranging in age from 9 months to 16 years, living in a three-room shack off Highway No. 8. Mother was cut off aid when her last child (out of wedlock) was born. She is employed as a day worker rotating between two white families. Her average earnings are \$15.00 weekly.

I first heard of Miss Jessie Mae from a young man who expressed concern for one of her daughters who frequently had "black-out spells" that lasted for hours. To his knowledge the child had never been seen by an M.D. Upon arrival, I found seven children playing in the yard. The older girl in the group (age 11) was 'caring' for the baby who was nursing himself on bean soup while resting in a bed made out of a paper box. Although the temperature was 40 degrees, four of the children were without



New Housing

shoes and coats. A five-year-old girl had a nasty open wound on her foot, covered with layers of dry blood and dirt. We were told by a neighbor that the toe had been broken by an axe blow. When questioned regarding care, she stated that children usually seem to get well fast and that most people didn't bother to take them to the doctor.

Miss Jessie Mae arrived after I'd been there for about one-half hour and related the following information regarding her situation:

1. She had been burned out nine months ago and owned one bed, a table, and three chairs. Straw mats were used by the smaller children.

2. The children were out of school for lack of shoes and clothing.

3. She didn't have money to see the doctor.

4. She realized that the baby needed better attention, but she had ten others to feed.

5. She gave the children grits for breakfast, pecans for lunch, and rice, beans, and greens for supper. Fatback was too high but sometimes she fished and occasionally the boys would run down a rabbit."

"Case 2. Mr. Johnny and family. Mr. Johnny's family consisted of a wife and nine children. Mr. Johnny was in bed with "miseries" in the chest and back. He had not seen a doctor, but his wife was consid-

ered by him to be a fairly good nurse. He'd like to see a doctor, but didn't have the money. He did not know of the local health department.

The source of income was cotton picking and chopping. His wife did day work when she could find it.

Mr. Johnny coughed frequently and spit in a tin can used for that purpose."

"Case No. 3. Miss Willie B. and family. Miss Willie B. is the mother of five and is expecting in April. She was proud of the fact that neither she nor any of her children had ever needed to see a doctor. Three of the children had been delivered by midwife, two by ladies in the neighborhood.

She had heard of the Bolivar County Health Department but 'never needed it.' She also stated that she had lost her fourth baby at birth, but 'it would have died anyway because it came too early.' Her source of income was work in the cotton fields. She doesn't get federal surplus foods but friends share food with her."

FULL-SCALE AMBULATORY HEALTH CENTER

It is this situation of need that Tufts plans to tackle, as a demonstration and research project, by the establishment of a full-scale ambulatory health center. Like the center at Columbia Point, it will have full physician examining-consulting facilities, an emergency room, laboratories, x-ray and other services. Like Columbia Point, it will be involved heavily in health education and health-careers training of local residents. Like Columbia Point, it will have the full-time services of physicians, community health nurses, health educators, and similar professionals and staff.

But there are some striking—and important differences. While Columbia Point's 6,000 residents live on a 15-acre site, all within five minutes of the health center, the Tufts-Delta Health Center's target area will be among the 14,000 persons in the northern districts of Bolivar County, an area of some 400 square miles, necessitating heavy



A Cotton Gin near Mound Bayou

reliance on out-reach, vehicles, and sub-centers; in addition, less intensive services will be provided to the most impoverished population in other areas of the county. While all of the full-time Tufts faculty and staff at Columbia Point live in Boston, most of the Tufts faculty at the Delta Health Center—including the author—will be moving to, and living in, Mound Bayou. While the Boston Housing Authority provided the physical facility for the Columbia Point Health Center, Tufts will have to find its own facility in the south. Fortunately, two very substantial but uncompleted buildings—originally planned for a new (but unrealized) junior college campus near Mound Bayou—are located only two miles from the town, and it is hoped that these J. P. Campbell College buildings can be completed and equipped as the Tufts-Delta Health Center.

MOUND BAYOU

Mound Bayou itself is a small (population, 1380) but fascinating community. Founded just after the Civil War, it is the oldest all-Negro town in the United States, and it serves as a regional medical center

(since it has two small hospitals), educational center and social center for the Negro population of the entire northern Delta area. It has its own town government, a non-profit, chartered economic development corporation, a district high school and elementary school, a parochial school, and other facilities. Like the rest of the Delta, it also has needs—for better housing and for industrial development in particular.

Extensive field work has already been completed in the Bolivar County area, including meetings with many local residents, with the Bolivar County Community Action Program, with state and county health departments and local physicians, with civic and religious leaders, and with the leaders and residents of Mound Bayou. Plans for housing construction are under way, plans for health center construction are being drawn up, staffing patterns are set, arrangements for cooperative relationships with the two Mound Bayou hospitals are being developed, health education and community organization efforts have already begun, staff recruitment has started—and we hope that within months the Tufts-Delta Health Center will be a reality.

Tufts' New Community Health Division

H. Jack Geiger, M.D., Professor of Preventive Medicine, has been named head of a newly-created Division of Community Health in the Department of Preventive Medicine at the University's School of Medicine. Tufts' New Community Health Program was written up by Count D. Gibson, Jr., M.D., and Herman Jack Geiger, M.D. in the Tufts Medical Alumni Bulletin 24:18, Nov. 1965.

Dr. Geiger is Project Co-Director of the Tufts Comprehensive Community Health Action Program, which includes the Tufts Health Center at Columbia Point, Boston,

and a second Health Center and program which is being developed in Mississippi. The Co-Directorship is shared with Dr. Count D. Gibson, Jr., Professor and Chairman of the Department of Preventive Medicine.

Dr. Geiger has received an award of a five-year Milbank Faculty Fellowship for the period 1966 to 1971. The award of \$40,000 was made by the Milbank Memorial Fund to enable Dr. Geiger to pursue his program of research and development in social and community medicine, evaluation of teaching and training in community health,