

SUCCESSFUL RURAL HEALTH PROGRAMS IN PERSISTENT POVERTY COUNTIES IN  
THE SOUTHEAST UNITED STATES

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL  
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT  
OF THE REQUIREMENTS FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2008

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To my beloved Parents who watch over me, and to my husband who loves and nourishes me.

## ACKNOWLEDGMENTS

I thank Leslie Lieberman, my friend and mentor. She has been an inspiration to me since the moment I met her in 1990. We have worked together, laughed together, and cried together. Her enthusiasm and encouragement have been unwavering. Leslie offered me the opportunity and experience to work on collaborative interdisciplinary research projects, where applied anthropology came to life.

Many others have guided and supported me through the process of the dissertation. Foremost, members of my committee have generously provided valuable insight and guidance. Dr. Michael Reid, professor at the College of Public Health at University of South Florida and the Office of Rural Health Policy staff were invaluable in aiding my understanding of the political process of health policy at the federal level. Dr. Robert Brehl, a global health systems expert and dear friend, listened when I was confused, offered editorial suggestions when my logic failed me, and championed my work when I needed it the most. Most of all, I thank my husband, Van. Ultimately, this dissertation is a product of my loving husband's support, guidance, and encouragement. He has endured years of my graduate studies, absences while I was in the field, read *all* of the early drafts. And for the last stages of the dissertation, he has cooked, cleaned, and taken care of me so that I may finish my degree. And then there are my beloved Irish Wolfhounds . . . Brenainn, Cearbhall, and Campbell.

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## LIST OF ABBREVIATIONS

AAA	American Anthropological Association
AAPA	American Association of Physical Anthropologists
ACS	American Community Survey
ASEC	Annual Social and Economic Supplement
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center, federally qualified health center
CMS	Centers for Medicare and Medicaid (HHS agency)
CPS	Current Population Survey
EPA	United States Environmental Protection Agency
FQHC	Federally Qualified Health Center
GDP	Gross domestic product
HCFA	Health Care Financing Agency now CMS (HHS agency)
HEW	Health Education and Welfare (predecessor to HHS)
HHS	United States Department of Health and Human Services.
HRSA	Health Resources and Services Administration (HHS agency)
ICD-9	International Classification of Diseases, 9 <sup>th</sup> edition
ICD-10	International Classification of Diseases, 10 <sup>th</sup> edition
IHS	Indian Health Service (HHS Agency)
NAPA	National Association of Professional Anthropologists
NHSC	National Health Service Corps (housed in HRSA)
OMB	Executive Office of the President, Office of Management and Budget
RAP	Rapid assessment procedures
USAID	United States Agency for International Development

USDA	United States Department of Agriculture
WAHS	West Alabama Health Services
WIC	Special Supplemental Nutrition Program for Women and Infant Children
WHO	World Health Organization

Abstract of Dissertation Presented to the Graduate School  
of the University of Florida in Partial Fulfillment of the  
Requirements for the Degree of Doctor of Philosophy

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By

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December 2008

Chair: Leslie Sue Lieberman

Major: Anthropology

Health care is the foundation that is required to ensure a minimally accepted quality of life. Persistent poverty counties exist throughout the entire United States but those in the southeast have persisted for generations, and, as such, require interventions to make significant changes in the health of the poorest and most vulnerable populations. This dissertation examines three successful interventions in the context of a political economy of health paradigm and how federal laws, agencies, and health policies contribute to the health of the local communities. The theoretical and methodological approaches in conducting the research and the dissertation are grounded in applied anthropology and public health. The research project conducted fieldwork at the three sites and was designed to provide information for federal level decision makers to use in crafting national health policies.

## CHAPTER 1 OVERVIEW

### **Introduction**

#### **Statement of the Problem**

Within the United States there remain pockets of sustained rural poverty identified by the federal government as persistent poverty counties (USDA 1994). Persistent poverty counties are rural by definition and have had sustained poverty rates of 20% or higher for the decennial years of 1960, 1970, 1980, and 1990. Based on 1990 data, the largest concentration of persistent poverty counties was located in the South (82.8%) (USDA 1994a:35). Persistent poverty counties in the South represent a large vulnerable population of nearly 9.5 million (USDA 1994a:34). Furthermore, rural locales historically have fewer health resources than urban areas (Helseth 2008; Ricketts 1999; Wilhide 2002).

*The goal of this dissertation is to examine federal health policies and their impact on rural health programs in persistent poverty counties in the South.* A political economy of health paradigm is used to elucidate these policies and practices and to inform future recommendations. The dissertation contributes to the growing anthropological literature on health policy from the perspective of “anthropology of policy.” Arachu Castro and Merrill Singer define anthropology of policy as, “studying and assessing the process of decision making, the actions of and influences on decision makers, and the impact of policy on human lives,” or in other words, an “informed critique of policy” (2004:xiii). Three case studies are used to exemplify this approach and its value to policy makers.

#### **Theoretical Framework**

Within the discipline of anthropology, an ever increasing number of medical anthropologists are conducting research on issues of health *vis-à-vis* health policy (see, for

example, Castro and Singer 2004). One result is the development of the Critical Anthropology for Global Health Study Group within the Society for Medical Anthropology. The mission of the group is to explore current and past socioeconomic and political processes to identify and expose structural patterns that undermine the health of poor and marginalized groups (Society for Medical Anthropology 2008). This dissertation embodies the philosophy and spirit of that group.

The Society for Medical Anthropology was formed by applied medical anthropologists in the late 1960s and became a formal section of the American Anthropological Association in 1972. Merrill Singer and Hans Baer (2007:18) define applied anthropology as “the application of anthropological theories, concepts, and methods to solving problems in the world.”<sup>1</sup> Barbara Rylko-Bauer and colleagues (2006:187) argue that most, if not all contemporary anthropology, is applied in nature and prefer the term “anthropology in use” to applied anthropology. Today, more than ever before, medical anthropologists are devoted to solving current problems related to the health and wellbeing of people within the United States as well as internationally.

Anthropologists historically have made valuable contributions to policy development through basic research and application (Boek 1995; Boone 1991; Chambers 1989; Doughty 1987; Gearing 1973; Holmberg 1970 [1965]; Kimball 1987; O’Reilly 1991; Paul 1955; Schensul 1973, 1974; Spicer 1952; Tax 1950,1970; van Willigen 1994; Weaver 1985). Two anthropological definitions of policy, for example, are: “a set of options from which a decision maker must select a course of action” (Angrosino and Whiteford 1987:485), and “those intentions which can be associated with deliberate actions in any sphere of human activity” (Chambers 1989:38). Policy studies identify a process consisting of fluid, discernable phases, or stages such as: (1) recognition of an issue, problem, or agenda; (2) formulation of policy through

design, planning, and public support building; (3) decision making and adoption of policy; (4) implementation of policy; (5) evaluation; and (6) revision or termination. The process is political and economic as well as strategies of action and is predicated on planned change (Chambers 1989:38-39; van Willigen 2002:161-162). Federal policies provide excellent examples of the complexities of the policy process. Applied anthropologists are substantively engaged in all phases of the policy process.<sup>2</sup>

The basic premise of political economy of health paradigm asserts health phenomena are embedded in culture and that culture is dominated by political and economic forces (Morsey 1996; Singer and Baer 1995).<sup>3</sup> Merrill Singer and Arachu Castro (2004:xiii) and Paul Farmer (2004:281) include racism and poverty as large-scale forces which contribute to “personal distress and disease” (Farmer 2007:281). Consistent with the political economy of health paradigm, Paul Farmer seeks to understand “both the individual experience and the larger social matrix in which it is embedded to understand how various large-scale social forces come to be translated into personal distress and disease” (2007:281; see also, Farmer 2005). For Farmer, the examination of such social forces exposes structural violence. As such, the study of large-scale sociocultural forces (processes) begins with an examination of the historical context. I order the large-scale processes in a hierarchical placement (Figure 1). Another component of the political economy of health paradigm is the examination of sociocultural relationships and linkages between the various large-scale processes. Singer and Baer (2007:8) point out that social relationships (e.g., ethnic relationships) and social structures that control access to resources are fundamental factors (variables) of health. Relationships of power also are of critical concern to medical anthropologists using this paradigm. For example, there is a striking power dissonance

between federal legislation, federal agencies and the resultant health policies and health care provision in community health centers located in persistent poverty counties.

The political economy of health paradigm as conceptualized for this dissertation focuses attention on the interaction of forces acting at all levels from the macro-historical context to the local community. That is to say, the concentric circles in Figure 1 represent hierarchical levels of organization from which various sociocultural forces emanate their influence. These rings provide a framework for visualization of the network of interactions between actors at each level of the hierarchy.

The first ring, representing the larger historical context, has overarching importance and sets the stage for examination and interpretation of the linkages and relationships at all levels, crucial to an understanding of the implementation of rural health programs. The historical context provides insight through exposing the roots of current health policies allowing for the elucidation of those factors driving new policies and programs. For example, the Civil Rights legislation of the 1960s has stimulated the development of policies establishing a network of southern rural community health clinics furthering the concept that black populations have an equal right to many benefits enjoyed by the majority population (see Chambers 1989:57-60; HHS 2008c).

The political economy ring represents political and economic forces and actors transcending national, state and local geopolitical boundaries and operating in a historical context that establishes their authority. These include national executive agencies, state level medical authorities, private donors and philanthropic organizations, medical professional societies, and even individuals who are in position to establish health care policies. These actors may have a wide variety of legal and social authority and often do not act in concert with each

other. The relationships between these forces and actors reflect their political and economic power and often lead them to pursue opposing goals.

The third ring, which represents poverty and racism, directly impacts local health care availability. Poverty and racism influence power and economic relationships in each of the rings in this model. They arise from the historical situations that generated the current social and cultural status of the population. Intergenerational poverty and institutionalized racism were the root causes of the sociocultural circumstances that gave rise to the local programs described in this dissertation. They were successful local responses to widespread health and social disparities that, unfortunately, persist today (see, [http://www.raconline.org/info\\_guides/disparities/](http://www.raconline.org/info_guides/disparities/) for a list of current publications on health disparities).

The fourth ring represents the micro level of community health programs in persistent poverty counties. This model seeks to elucidate the interrelationships between these programs and forces and actors in each of the other rings. In particular, this theoretical model facilitates understanding of the status of the community health programs as they are affected over time by changing policy emanating from the second ring.

Consistent with the political economy of health paradigm, this model further explores the socioeconomic conditions which contribute to poor health outcomes for community members in ring five.<sup>4</sup> The socioeconomic variables chosen for this model include poverty level, per capita income, unemployment rate, and educational attainment for each county. Indicators of health outcomes such as, selected adult mortality rates and infant mortality rates were employed to ascertain the health of the communities.

The discipline of anthropology, with its exceptional use of cross cultural comparative method and rich ethnographies, is well positioned to contribute to contemporary health research

*vis-à-vis* other disciplines active in the pursuit of health research. Anthropologists' approach of giving voice to marginalized and disenfranchised groups within context of the social milieu, comparative analysis, and expert attention to cultural variables provide a unique perspective on health issues. Applied medical anthropologists who employ a political economy of health paradigm further our understanding of current health challenges and are uniquely prepared to contribute to health policy research as well as to provide solutions to current health problems.

### **Methods**

Primary and secondary data collection methods included participant observation, interviews, rapid assessment procedures, surveys, and archival retrieval (see, DeWalt et al. 1998; Schensul et al. 1999; Scrimshaw and Gleason 1992; Scrimshaw and Hurato 1987; Weller 1998). Data collection for the dissertation occurred over six research stages spanning from 1993 to the present: (1) original case study field research, 1993-1994; (2) supplemental research on migrant farmworkers, 1994-1999; (3) supplemental field research, 1995; (4) internship at the Federal Office of Rural Health Policy, 2001; (5) archival research, 2002-2007; and (6) case study follow-up research, 2007-2008. The five stages of the research required different methodological approaches, and, thus, are best understood if examined separately. The first stage, the case study project, was the result of interdisciplinary planning and collaboration and is an example of applied anthropology policy research using rapid assessment procedures and ethnography.

#### **Original Ethnographic Policy Project, 1993-1994: Successful Rural Health Programs in Persistent Poverty Counties in the Southeast United States**

The three case studies reported here evolved from of a larger research project administered by University of Florida at the Rural Health Research Center. The project was funded in 1992 by the Office of Rural Health Policy, an office within the Health Resources and Services Administration, United States Department of Health and Human Services. The research was

designed to inform and guide federal policy through recommendations for improving health care in rural, persistent low income counties (PLI) in the South. A total of six ethnographic case studies were conducted of “successfully initiated” health programs in economically depressed areas of the rural South (internal document dated January 8, 1993). The ethnographies covered five Southern states: Alabama, Arkansas, Florida, Mississippi, and Tennessee.

### **Contract research and the PLI research team**

Leslie Sue Lieberman, PhD., Associate Professor of Anthropology and Pediatrics was contracted to assist in developing the case studies, to conduct the site visits, and to write policy briefs based on the findings of the case studies. She was an integral part of the interdisciplinary research team headed by Dr. Lionel Beaulieu, Professor of Rural Sociology, and included three professors from the Institute for Food and Agricultural Sciences, two anthropologists, and one doctoral student in political science. I joined the interdisciplinary research team under the guidance of Dr. Lieberman. As a member of the research team, my duties included collaborating in selection of the case studies, preparing data collection instruments, and participating in ethnographic fieldwork at six sites with Dr. Lieberman. Prior to my joining the research team a group of 40 sites had been selected according to preliminary research design criteria.

### **Development of case studies**

The case study component of the research was officially described as Successful Rural Health Programs. The identification of the successful programs and the ultimate selection of six for site visits was not random, but was a team decision based on a modified Delphi method of three rounds of inquiry to reach a consensus on the programs. The Delphi method is a systematic, interactive forecasting tool which relies on a panel of independent experts who are given feedback after each round of inquiry (Rowe and Wright 2001). There were three phases to the case study research:

Phase I: Identify government and voluntary health agencies at the state, district, and county levels;

Phase II: Development of letters to send to key agencies as described in Phase I, and of survey questionnaires for health programs recommended by the key agencies; and

Phase III: Select six programs for on-site study based on responses from Phase II inquiries.

In the process of Phase I, health agencies were identified such as, state public health departments, regional nongovernmental health agencies (e.g., the American Heart Association, the American Cancer Society), and universities. In Phase II, a business letter was collaboratively designed and mailed to the health entities identified in Phase I. The letter asked key health professionals to identify rural health initiatives, programs, or projects that had made a positive impact on the health of communities they served in persistent poverty counties within their purview (the letter included an attached list of the persistent poverty counties for the state). Once such programs had been identified, survey questionnaires were mailed to key contact personnel at the successful rural health programs. It was from these surveys, in Phase III, that the case studies were chosen.

Two essential criteria had to be met to be chosen for a site visit. First, it had to be “successful” and second, it had to be located in a persistent poverty county in the southeastern United States. “Successful” was defined as a program that had made a significant impact on the health of the community. The successful programs identified by state and local organizations and agencies were defined as such by the referring agency or organization and not by the nominated program coordinators. Forty successful rural programs in persistent poverty counties were identified. The programs encompassed a wide range for example, state health department state-wide programs, university based programs, county extension programs, regional programs, county health department programs, March of Dimes programs, American Heart Association programs, hospital outreach programs, American Cancer programs, church programs, and

programs supported by nonprofit organizations. Out of the 40 programs, the research team selected six for site visits located in five states: Alabama, Arkansas, Florida, Mississippi, and two sites in Tennessee. Given the complexities of the six case studies and the vast amount of data collected, the three most robust cases were chosen for inclusion in this study. A brief description of the three case studies not included in the dissertation follows.

**Say Y.E.S.:** The Say Y.E.S. (to Success) project, an acronym for Youth Educated and Self-motivated, was a joint initiative between the Henry Kaiser Family Foundation and the Arkansas Department of Health. In the late 1980s, the then Arkansas Department of Health Director, Dr. Joycelyn Elders (1987-1993) established the Arkansas Health Promotion Health Promotion Project, of which Say Y.E.S. was one component.<sup>5</sup> At that time, state authorities recognized adolescent pregnancy as a critical problem in Arkansas (the state ranked number two in the nation according to a pamphlet outlining the project). Chicot County in southeast Arkansas had the highest adolescent pregnancy rate in the state. State health officials selected Eudora, in Chicot County, to receive funding and technical assistance for an adolescent pregnancy prevention project. The initiative was designed by the Chicot County Local Planning Group, implemented by dynamic community members, and supervised by a state public health department program officer. Say Y.E.S. began in 1991 and was funded for three years. This program provided services to youths between the ages of five and 19.

**Center for Maternal Child Health and Education.** This program was planned, designed, and implemented within the De Porres Health Center (established in 1981 by Dominican nuns from Sinsinawa, Wisconsin). The program primarily served blacks in Quitman County, Mississippi in the heart of the Mississippi Delta in the northeast corner of Mississippi.<sup>6</sup> In 1992, the county had been cited as having the highest adolescent pregnancy rate (81.69 per

1,000 births) in Mississippi (Mississippi State Department of Health 1994:15). The program provided an array of services including health education, parenting classes, limited day care, and G.E.D. classes in a nurturing environment. All clients had access to the health center's medical services as well.

**Nurse-Midwifery Services of Tri-County Family Health Care.** This program was located in North Florida, east of Tallahassee, providing perinatal care to Jefferson, Madison, and Taylor Counties. Based on certified nurse-midwifery services, the program filled a critical need in the service catchment area due to the complete absence of obstetrical-gynecological physicians. Prenatal and postnatal care were provided—along with well-baby, family planning, and routine gynecological services—at two service sites in Madison County with collaborative agreements with county public health offices in Jefferson and Taylor Counties. Nurse midwives were supervised by six OB/GYN physicians in Tallahassee, and all deliveries were carried out at the Tallahassee Community Hospital. The majority of clients served were blacks, most of who were covered under Medicaid.

### **Fieldwork methods**

The methodology for the fieldwork research was based on rapid assessment procedures (RAP): *Rapid Assessment Procedures for Nutritional and Primary Health Care: Anthropological to Improving Program Effectiveness* (Scrimshaw and Hurato 1987) and *Soundings: Rapid and Reliable Research Methods for Practicing Anthropology*, van Willigen and Finan (1991). Each site visit was completed within two to four days. This methodology is well suited for interdisciplinary research where the project is on a short time-line and “deliverables,” in this case—the policy recommendations were given a relatively short turnaround period.

### **Dissolution of the research team**

The research had piqued my interest in applied anthropology and the health status of migrant farmworkers, and I soon transferred to the University of South Florida to do course work in public health and applied medical anthropology. The research team disbanded shortly after the site visits had been completed, but before the research had been analyzed and policy briefs had been written. After completing course work at University of South Florida, I returned to University of Florida to finish my dissertation on three of the original case studies.

### **Supplemental Research on Migrant Farmworkers, 1994-1999**

During my applied studies at University of South Florida, (fall) 1994 to 1999, my primary research subject was the health of migrant farmworkers. I completed a number of papers concerning various issues: historical analysis of farmworkers in the United States, tuberculosis, green tobacco sickness, and political economy to name a few. I completed further research on migrant farmworkers during the spring of 1995 and 1996 by interviewing key governmental and nongovernmental agency personnel at the national and regional level involved with migrant health. I first interviewed the Public Health Service officer in Atlanta (Health and Human Services, Health Resources and Services Administration) responsible for the geographic South and who directed the regional Migrant Health Program. Other key individuals involved with migrant health were interviewed also for example, the Acting Director of the Migrant Health Program at HRSA in Washington D.C.

### **Migrant Farmworker Health Centers**

Supplemental field research to the Bebé Sano case study was conducted in the summer of 1995. This second site visit to the Bebé Sano program was conducted as part of a research project examining the health needs of migrant farmworkers in eastern Tennessee, supported in part, by the Migrant Health Program, Bureau of Primary Health Care, Health Resources and

Services Administration. The project consisted of three site visits to migrant farmworker health clinics. The research methods for the site visits were broadly patterned after the original case study research using rapid assessment procedures and in-depth interviews, with the addition of focus groups, surveys, and participant-observation. Data from the 1995 research have been incorporated into the *Bebé Sano* case study.

### **Office of Rural Health Policy Internship, 2001**

I completed a summer internship at the Office of Rural Health Policy in 2001. While working at the Office of Rural Health Policy, I was encouraged to spend time on “the Hill” observing testimonies and briefings relating to health and rural health issues. I spent a considerable amount of time on Capitol Hill observing the legislative health policy process on a variety of issues, which included Congressional hearings, testimony, and committee meetings, as well as briefings by special interest groups for legislative staff and policy interested parties. One case in point was the testimony before the House of Representatives’ Committee on Ways and Means, Subcommittee of Health, on Rural Health Care in Medicine held on June 12, 2001.<sup>7</sup> The hearing was before the Medicare Payment Advisory Commission discussing the commission’s new report on *Medicare in Rural America*. Testifying before the commission were Glenn Hackbarth, J.D., Chairman of the Medicare Payment Advisory Commission; Keith Mueller, Ph.D., Director of the Rural Policy Research Institute, Center for Rural Health Policy Analysis, University of Nebraska Medical Center; Kathleen Dalton, Ph.D., Fellow at the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill; and Curt Mueller, Ph.D., Director of Project HOPE, Walsh Center for Policy Analysis, Bethesda, Maryland. The hearing had been called to develop policies to ameliorate inequitable Medicare rates between urban and rural locales.

Most of the witnesses were academicians from university based rural health research centers that were funded by the Office of Rural Health Policy. The report, *Medicare in Rural America*, was produced by the research centers in consultation with the Office of Rural Health Policy. The Congressional hearing before the very powerful Committee on Ways and Means was a critical legislative step in the process to improve the fiscal health of rural medical providers and hospitals. The Office of Rural Health Policy staff viewed it as a historical step.

At the HRSA Office of Rural Health Policy headquarters, I attended meetings involving numerous bureaus and offices within HRSA, participated in weekly staff meetings, and worked on small projects. For example, I worked on the Mississippi Delta project providing data on available health resources and sociodemographic and socioeconomic characteristics of the counties in the region. I was also tasked to provide similar data on western Alabama for an official multi-governmental site visit when HRSA funding to West Alabama Health Services, one of the three case studies in this the dissertation, was terminated. Mainly I was an anthropologist conducting participant-observation. My focus was to understand what role the Office of Rural Health Policy played in rural health.

### **Archival Research, 2002-2007**

Archival research was necessary to obtain supporting secondary data covering a range of socioeconomic, sociocultural, and historical issues. In some cases, data were collected electronically via the internet, in others, national agency libraries were access. Data were also procured through direct contacts with government agencies. Additional archival data were collected through the following governmental agencies: United States Census Bureau, United States Department of Health and Human Services (e.g., HRSA, CMS, CDC), United States Department of Agriculture, Alabama Department of Public Health, United States Department of Labor, Tennessee Department of Health, and the Tennessee Department of Agriculture.

Furthermore, additional data not available through public sources were acquired through the Freedom of Information Act (FOIA).<sup>8</sup> From 2001 to 2003, I requested information on the three programs from the HRSA, the agency providing funding for community health centers, with the intent of triangulating data collected during the 1994 site visits. The results were mixed. HRSA does not keep programs records beyond a certain time, according to sources at the Bureau of Primary Health Care. The earliest FIOA data were from 1999; therefore, the FOIA data were only helpful for the addendum section of the case study. Availability of information through FOIA requests varied greatly between the three sites. For one community health center there was a wealth of information through the grant proposals submitted to the agency for funding. After multiple FOIA requests, HRSA released three grant applications, site multiple site visit reports, and limited personal communication between West Alabama Health Services and HRSA, but cited legal issues involving current criminal investigations in obtaining additional data. For the three case study, FOIA request returned little substantive data.

### **Addendum Data, 2008**

The final data collection was completed after the case studies had been written, for an up-to-date report on “where they are now.” Data were collected through follow-up telephone interviews with key informants for all sites. Where noted, addendum data were also supplemented by additional sources such as the HRSA FOIA data discussed above, census data, state health reports, and related newspaper articles.

### **Case Study Organization**

The three case study chapters are organized around three data components: (1) contextual setting, (2) primary data collected from the 1994 site visits (they are in turn organized into two main sections: program (agency) history and description of the program (agency), and (3) addendum containing follow-up information describing the current status of the programs and

agencies. The contextual setting examines a combination of historical elements, sociodemographic indicators, socioeconomic indicators, and health outcomes. For contextual purposes, the sociodemographic and socioeconomic indicators are based on contemporaneous data at the time of the 1994 research using 1990 census data. Health outcome data are based on the Centers for the Control of Diseases and Prevention's CDC Wonder database using ICD-9 codes. Health outcomes are three-year averages for the years 1992-1994. Each case study is unique, thus the health outcomes are tailored to the context of the programs.

Sociodemographic indicators include total population; size of county as measured by square miles; population density measured by persons per square mile; percentage of population by ethnic group; and percentage of the population rural. Socioeconomic indicators include poverty as measured by percentage of all persons living in poverty; per capital income; unemployment rate as measured percentage of population unemployed; and educational attainment as measured by percentage all persons ages 25 years or older with a high school diploma or its equivalent. Health outcomes include mortality rates for all causes, heart disease mortality rates, cancer rates, cerebrovascular rates, suicide rates, infant mortality rates, and, in some cases, total birth rates, adolescent (ages 10-17) pregnancy and birth rates. Total mortality rates are age-adjusted, per 100,000. Infant mortality rates are per 1,000 live births; and pregnancy and birth rates are per 1,000 women of the age range specified. All of the selected sociodemographic, socioeconomic, and health data are contrasted to U.S., state, and catchment area populations.

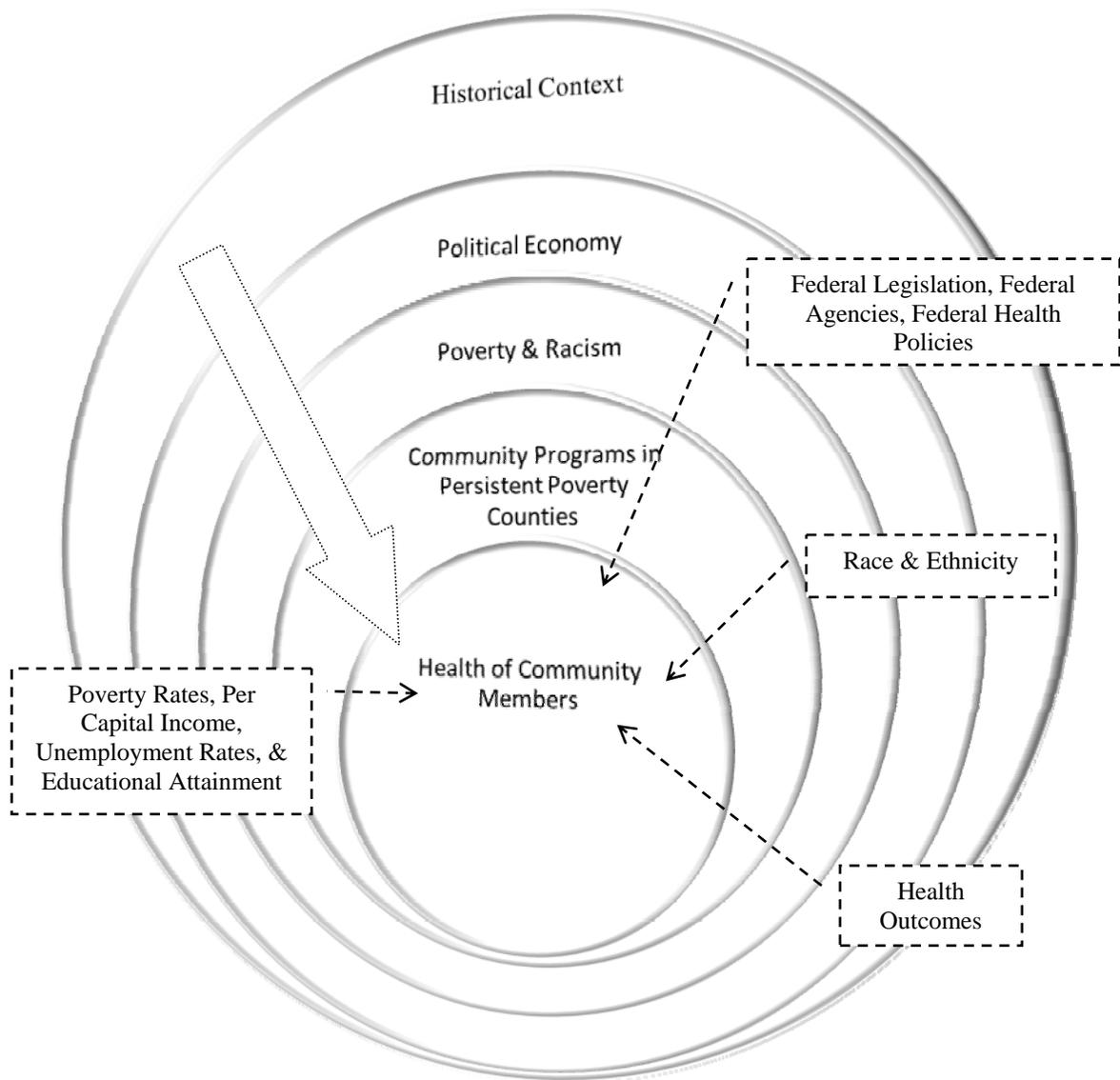


Figure 1-1. Political economy of health paradigm as conceptualized for the framework of the dissertation: large-scale processes and discrete variables impacting health in persistent poverty counties in the rural South.

## Notes

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<sup>1</sup> See also, Chambers 1986:x; Chapple 1955:2-3; Eddy and Partridge 1987; Foster 1969:54; Kushner 1994:188; Reining 1962:1866; Stavenhagen 1971:339; and van Willigen 1993:8 for additional definitions of applied anthropology.

<sup>2</sup>The six phases of the policy process is based on Michael Reid's interpretation of the process. Dr. Reid is a professor at the College of Public Health, University of South Florida and teaches a course on Health Policy and Politics. Chambers (1989:41) defines the process in four stages: formulation, planning, implementation, and review, while others describe it as a policy cycle (Lammers 1997; Angrosino and Whiteford 1987).

<sup>3</sup> The concepts of political forces and economic forces as processes are based on Marxist ideology (Marx 1904 [1859]:203).

<sup>4</sup> Health researchers have long recognized there is a decisive link between health and socioeconomic status (Berkman and Kawachi 2000; Graham 2004; Link and Phelan 1995; Marmot and Wilkinson 1999; Shaw et al. 1999). Medical sociologists Bruce Link and Jo Phelan (1995:84-87) argue that social conditions are fundamental causes of disease due to differential access to basic resources, which they define as money, knowledge, power, prestige, and social support. Access to these basic resources is the major factor in determining how susceptible people are to disease, and therefore social determinants such as race, ethnicity and poverty must be contextualized in order to be understood. This is not a new concept, in 1848, Rudolf Virchow, a clinical pathologist, reported the link between poverty and ethnicity as a major determinate of poor health (Singer and Baer 1995:19-21).

<sup>5</sup> Dr. Joycelyn Elders was the U.S. Surgeon General from September 1993 to December 1994.

<sup>6</sup> The county, as we drove through the catchment area, was the most economically depressed we had encountered during the site visits. We found ourselves in what appeared to be a third-world country. There was no business section or stores. Finding a gas station was problematic.

<sup>7</sup> At the Office of Rural Health Policy, the hearing was referred to as the "MedPAC hearing," Medicare Payment Advisory Commission, a hearing for the "roll out" of the new report to Congress, "Medicare in Rural America," which they were stakeholders

<sup>8</sup> The FIOA request was broadly defined: I requested any information on the three organizations, and not specifically a program.

## CHAPTER 2 THE RURAL SOUTH: A PROFILE DERIVED FROM FEDERAL POLICIES

### **Introduction**

The context of rural health in the South as part of the macro health care system of the United States requires a clear understanding of how the United States health care system compares to other analogous nations. Common comparisons used by health researchers are made between member nations of the Organisation for Economic Co-operation and Development (OECD). The thirty OECD nations are democratic nation states based on capitalist economies (OECD 2008a; 2008b).<sup>1</sup> Based on such comparisons, the U.S. care system is the most costly and usually has less favorable outcomes on many critical measures (Cylus and Anderson 2007; Davis et al. 2007; Kaiser Family Foundation 2007a; Nolte and McKee 2008; World Health Organization [WHO] 2000).<sup>2</sup> WHO, in 2000, ranked the U.S. health care system as 37<sup>th</sup> among 191 global nations (WHO 2000).

### **Race and Ethnicity and U.S. Policy of Enumeration**

The South's agrarian roots and their relationship with the practice of slavery from the 17<sup>th</sup> century through the mid-19<sup>th</sup> century produced a unique social order unlike others across the United States (see, for example, Morris 1996; Ruef and Fletcher 2003). Resultant patterns of structural inequality and discrimination against blacks persist even into the 21<sup>st</sup> century (in the South) (Ruef and Fletcher). Moreover, the historical effects of slavery have had significant political, economic, religious, moral, and ethical ramifications that remain patently visible in the contemporary South. Since the founding of the English colonies and the establishment of black African slavery in the South, the Judeo-Christian heritage passed down through English law finds expression in cultural icons that were used to support and reinforce the establishment and continuance of racism (Morris 1996:262-271). As a poignant case in point, during the course of

the site visits in 1994, we came across a courthouse in rural Mississippi with the phrase “Obedience to the Law is Liberty” chiseled in stone across the façade (see Figure 2-1). This epigram served as a moral, religious, and legal allusion the hierarchical places, or duties, of masters and their slaves in society prior to the Civil War (Morris 1996:262-271; Spencer 1850). After the Civil War, this icon along with other iconic symbols (e.g., the Confederate flag, uniforms, and other Civil War memorabilia) stood as a constant reminder of the black’s social standing in the South.

Slavery and its historical legacy of racism are topics far too broad for the current discussion. Mindfulness of these concepts provides added clarity to the relationship between persistent poverty status in the South and the influence of federal policy in maintaining or relieving the plight of the disadvantaged in the rural South. Racism was deeply entrenched and permeated each of the case studies.<sup>3</sup>

The racial and ethnic categories established by U.S. Census Bureau policies have confounded the enumeration and the interpretation of health statistics for U.S. minority populations. Periodic revisions of racial and ethnic Census definitions significantly alter the categorization of population data among and between various racial and ethnic groups. Federal policies reify and perpetuate race as a valid “official” concept. Furthermore, these classifications are reflected in popular culture but are often misinterpreted and misused classifications of people. The U.S. Census Bureau reports on a wide assortment of sociodemographic and socioeconomic indicators. All of the variables cited within the dissertation for contextual and comparative methods thus are designed and reported based on federal definitions and policies. As a case in point, health outcome data are categorized and reported consistent with Executive Office of Management and Budget (OMB) definitions and guidelines. Federal policies designed

for the enumeration of the U.S. population are used in government agencies for a variety of purposes including health statistics used to inform health policies and to determine allocation of resources (OMB 1997). The OMB definitions and guidelines reify an official delineation of race and group membership in America through the decennial census.

Medical anthropologist Robert Hahn (1998) traces classification changes made to the decennial census of 1970 and 1980 demonstrating the U.S. Census Bureau's and the public's confusion over group membership. For example, Hahn (1998:264) found that of the people who identified themselves as "Hispanic" in the 1980 census 40% selected "other race" when asked what racial group they belonged to—they did not consider themselves racially white or black. The government's intent was, and is, to bifurcate Hispanics into black or White Hispanics, a categorization that is consistent with the historical racial bifurcation of the country into white or black (see Lott 1993). Hahn (1998:265) notes in another example, based on the 1980 census, that only 73% of the people who reported they were of "American Indian race" claimed American Indian ancestry; the other 27% claimed European or "other" ancestry. He attributes this incongruence to the respondents not understanding the terminology used in the census forms, but his examples also indicate basic conceptual differences between those who construct the official survey instruments used by the U.S. Census Bureau and those who respond to them.

The 1990 census classified the U.S. population in four primary racial groups: Asian, Black/Negro, Native Indian/Native Alaskan, and White. The 1990 census also included ethnic categories: Aleut, Asian American, Black, or Negro, Chinese, Eskimo, Filipino, Guamanian, Hawaiian, Indian American, Japanese, Korean, other, Asian Pacific Islander, Samoan, Vietnamese, White Hispanic origin of any race, and White not of Hispanic origin (AAA 2008). In 1997, OMB redefined the categories of race five categories and which were used for the 2000

census: Asian, Black/African American, Hawaiian/Pacific Islander, Native Indian/Native Alaskan, and White. The ethnicity categories were compressed to Hispanic and NonHispanic (RACE 2008). For the first time in the history of the census, respondents had the opportunity to classify themselves as more than one race. These multiracial categories have further confused the interpretation of Census data.

There is particular confusion regarding the terms race and ethnicity (Hahn 1998; Ahdieh and Hahn 1996). The terms are abstracted classifications that are culturally constructed as products of the political system (see Gravlee and Sweet 2008; Harrison 1997; Marks 1995; Molner 1992). As such, topologies of race and ethnicity provide little insight into contemporary genetic variation of living populations (see for example, the American Association of Physical Anthropologists' [AAPA] "Statement on Biological Aspects of Race" [1996]; American Anthropological Association 1998a; Harrison 1997:392-394; Hartigan 2006; Mukhopadhyay and Moses 1997:520-521; Smedley 2007). The American Anthropological Association's (AAA) official "Statement on Race" concludes: "Given what we know about the capacity of normal humans to achieve and function within any culture, we conclude that the present-day inequities between so-called racial groups are not consequences of their biological inheritance but products of historical and contemporary social, economic, educational, and political circumstances" (AAA 1998a).<sup>4</sup> In addition, the "AAPA Statement on Biological Aspects of Race" clearly states that "there is no national, religious, linguistic or cultural group or economic class that constitutes a race" (AAPA 1996). The American Anthropological Association has an educational program called "RACE: Are We So Different," which includes traveling museum exhibit, website (<http://www.understandingrace.org>), and educational curriculum to educate the public on the concept of race.

The latest census figures from 2000 demonstrate the three largest groups of the South were white, black, and Hispanic (U.S. Census Bureau 2007d).<sup>5</sup> The distribution of the three groups in 2007 was: white 75.1%, black 12.3%, and Hispanic 12.5%. The Hispanic population in the U.S. is the fastest growing group, with a 57.9% increase since 1990 (U.S. Census Bureau 2004). The Hispanic population now surpasses blacks by just over a half a million people (U.S. Census Bureau 2001b; U.S. Census Bureau 2002). In the South though, blacks outnumber Hispanics in every state except Florida where Hispanics represent 16.8% of the population and blacks represent 14.6%. Whites still remain the most populous group for every state in the South, although their ratios fluctuate from 95.0% in West Virginia to 64.1% in Mississippi (U.S. Census Bureau 2007d).

Forty-one percent (over 14 million) of all blacks counted in the 2000 decennial census lived in the South as compared to only 17% (5.9 million) of all Hispanics (Census Bureau 2001d). For every Southern state—except Kentucky and West Virginia—blacks surpass the national average of 12.3% ranging from 36.3% of the population in Mississippi to 14.6% in Florida (U.S. Census Bureau 2007d). Blacks have been concentrated in the rural South within the Cotton Belt region as a historical consequence of slavery (Beale 2004; U.S. Census Bureau 1904:11).<sup>6</sup>

It is important to distinguish between racial and ethnic subgroups within the general population to monitor health disparities that are masked in the aggregate data in what Singer and Clair refer to as an “ethnoepidemiological surveillance” (2003:434). For example, infant mortality rates are considered to be a sensitive indicator of a population’s health status as well as an index of living standards and availability of health care (Timmerick 1994:106; Williams, Baumslag, and Jelliffe 1994:180). At the aggregate national level, the infant mortality rate in

2003-2005 (three-year average) was 6.8 per 1,000 live births. However, when the data are disaggregated by racial and ethnic groups a different picture emerges: white infant mortality rate was 5.7 per 1,000 live births, and the black infant mortality rate was significantly higher, 13.8 per 1,000 live births—demonstrating a gross difference between the two groups (CDC 2007).<sup>7</sup>

### **Sociodemographic and Socioeconomic Characteristics of the South**

The Southeastern United States, for the purpose of the dissertation, is defined by the following twelve states: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia, collectively referred to as the South. Historically, the South has been pervasively rural, poorer, more extensively black, and deficient in health care resources compared to the rest of the country (U.S. Census Bureau 2001d, 2007a, 2007g, 2007h, 2007i; USDA 2001c; see also, Ricketts et al 1999). With few exceptions, the South, in contrast to other regions of the country, had the highest number of uninsured, highest poverty rate, lowest per capita income, highest unemployment rate, lowest educational attainment, and far worse health outcomes both in 1990 and 2000-2006.<sup>8,9</sup> For example, as of 2006, approximately 47 million people in the United States lacked any form of health insurance, and 43% of the uninsured resided in the South (U.S. Census Bureau 2007h). In the rural vestiges of the South these conditions are far more pronounced.

### **Poverty**

The South has been the poorest region in the continental United States for generations. In examining the historical poverty tables maintained by the U.S. Census Bureau, the South consistently has been the poorest region of the United States since 1959 (U.S. Census Bureau 2007a; see also, Cardiff Nd). Nearly 15 million people in the South were living in poverty in 2006—nearly 14% of the population (U.S. Census Bureau 2007g:11, 2007i). More revealing are the 2006 poverty levels for the minority populations in the South, as measured as a percent of the

population living in poverty: white 9.1%, black 23.1%, and Hispanic 21.7% (U.S. Census Bureau 2007i) (Table 2-1). There are well defined differences in access to economic resources between the three groups, although the poverty levels for all groups had improved since 1990 (U.S. Census Bureau 1993g). Urban and rural data for 2006 are also striking (Table 2-2).<sup>10</sup> White urban poverty level was 7.6% compared to 14.7% for white rural poverty; black urban poverty was 21.5% compared to 30% for black rural poverty; Hispanic urban poverty was 21.1 compared to 28.1% for Hispanic rural poverty (U.S. Census Bureau 2007i). These data illustrate that blacks living in the rural South are the most impoverished group of the three compared.

**Persistent poverty counties in the South.** Poverty and its effects are also patently evident at the county level. In the 1970s the USDA designed categories for rural counties based on policy relevant information to assist policy makers in funding and other decisions, as well as legislation, affecting specific issues of socioeconomic and political concern. One of these categories, persistent poverty counties, identified counties that historically have been desperately poor for generations. The original federal policy definition of a persistent poverty county was a nonmetro county that had poverty rates 20% or higher at the decennial data points of 1950, 1960, and 1970. During President Johnson's War on Poverty initiative, the identification of persistent poverty counties became a powerful tool for the federal government to allocate funds to areas most in need. By the 1990s, the persistent poverty definition was updated using the decennial data points 1960, 1970, 1980, and 1990 (USDA1994a). But by the mid-1990s, use of this policy category of persistent poverty counties waned from the federal government's ideology due to changes in definitions of some of the supporting criteria (Beale 2004; OMB 2006; USDA 2007).

According to the USDA, the federal government recognizes nine definitions of *rural* (UDSA 2007). The multiplicity of definitions makes data comparisons between federal agencies

particularly difficult. The U.S. Census Bureau uses six different definitions, the Office of Management and Budget uses one (the preferred definition advocated by the White House), and USDA uses two. Beginning with the 2000 decennial census, federal agencies that collect, tabulate and publish federal statistics are encouraged to use the OMB definition, which is based on the concept of metropolitan statistical areas, for “program administration and fund allocation purposes” (OMB 2006). Metropolitan statistical areas include “one or more counties containing a core urban area of 50,000 or more people, together with any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core” (USDA 2007). OMB defines rural as “all counties outside metropolitan areas in 2003 (based on 2000 census data)” (USDA 2007). This is a critical shift in federal policy boundaries.

The new definition of “rural” creates an alternative rural America.<sup>11</sup> With the new classification, less of the populace is rural, and thus, fewer federal dollars are required to fund rural issues. This one definitional change greatly impacts 12 out of 15 counties profiled in this dissertation: using the 2006 OMB definition for program administration and fund allocation, only seven counties are designated as nonmetropolitan (USDA 2007). For example, currently only one of the three case studies reported in this dissertation would qualify as rural research because only one primary county is designated as rural (nonmetropolitan) (USDA 2004a).<sup>12</sup> Along with USDA, the U.S. Census Bureau classifies the primary counties for Children and Family Services and West Alabama Health Services as metropolitan: Tipton County is now within the Memphis metro area, and Greene County, Alabama is now part of the Tuscaloosa metro area (U.S. Census Bureau 2000).

### **Per Capita Income**

Another indicator of poverty in the South is per capita income.<sup>13,14</sup> The average 2006 per capita income for the United States was \$25,267. Viewing per capita incomes for the three

largest groups nationwide, the per capita income for whites was the highest, \$27,951; black per capita income was the second highest, \$16,559; and Hispanics had the lowest per capita income level, \$14,736. Consistent with the regional poverty structure, the South's per capita income, at \$23,691, was lower than the national average and the lowest of the four regions. The per capita incomes in the South for the three groups were: white \$26,683, black \$15,856, and Hispanic \$14,583 (U.S. Census Bureau 2008).

### **Unemployment Rates**

The 2006 unemployment rate for the general U.S. population was 6.4%. White unemployment was 5.3% compared to 12.6% for blacks and 7.5% for Hispanics. In the South the unemployment rate was 6.5%, second only to the Midwest region where the unemployment rate was 6.7%. Blacks living in the Midwest also had the highest unemployment rate (16.4%) of the four regions. In all of the regions, blacks had the highest unemployment rate. Hispanics in all regions had relatively low unemployment rate, higher than whites, but significantly lower than the black rates.<sup>15</sup> In the South the white unemployment rate was five percent, the black rate was 11.8%, and the Hispanic rate was 6.8% (U.S. Census Bureau 2008).

### **Educational Attainment**

One startlingly observation we made in traveling through the South was the practice of intractable, racially segregated school systems at nearly all six sites. After the court ordered desegregation, whites responded by creating private Academies and staffing them with white teachers and administrators from the public schools, leaving black children just as they were before desegregation—segregated—albeit with improved school buildings previously occupied by white students. One informant recalling the process said that after the academies were established, funding for the school board was cut and newly elected black educational

administrators lacked the knowledge to run the school system, a process that was replicated throughout the South and continues today (see Whorisky 2007).

In 2006, 85.5% of the U.S. population 25 years or older had graduated from high school. Women were slightly more likely to have a high school diploma than men (85.9% versus 85.0% respectively) (U.S. Census Bureau 2007j). The white population had the highest education attainment rate (90.6%), followed by blacks (82.3%), then Hispanics (60.3%).<sup>16</sup> While these statistics show striking differences between the groups, educational attainment for all groups are dramatically higher than they were in 1990. The 1990 educational attainment for blacks was 66.2%, 50.8% for Hispanics, and 77.6% for whites (U.S. Census Bureau 2007j). Regionally, the South had the lowest educational attainment in 1990 and 2000 (U.S. Census Bureau 2003:3).

### **Access to Health Insurance**

Intrinsically linked to health and poverty is the availability of health insurance. As of 2006, nearly 20.5 million people in the South, 19% of the Southern population, had no form of health insurance (U.S. Census Bureau 2007h). Another 13 million Southerners were recipients of Medicaid and over 15 million were covered by Medicare. Taken together these three populations, the uninsured and those insured through Medicaid and Medicare, represent over 45 million people—nearly half of the Southern population (U.S. Census Bureau 2007h).

According to the National Rural Health Association (1999; Pol 2000:7), the rural South as of 1999 had the highest level of uninsured in the nation with minorities populations particularly at risk. For example, as of 2006, 53.1% of Southern blacks either lacked health insurance coverage, or were enrolled in Medicaid, or covered under Medicare. In comparison, 38.6% Southern whites fell in the same categories (U.S. Census Bureau 2007h). Of critical note is the burden these three populations place on local communities with limited health care resources, particularly in persistent poverty counties, for, in the rural South, the vast majority of the

uninsured, Medicaid, and Medicare recipients receive their health care from community health centers. Each group presents significant economic challenges to the Southern states: Medicare through its disproportionately lower reimbursement payment rates, Medicaid which requires state matching funds, and uninsured where indigent funding is nebulous at best.<sup>17</sup> It is clear that economic burden of these three groups in persistent poverty counties is on the increase with a stagnating economy and high unemployment rates.<sup>18, 19</sup>

### **Health Outcomes 2003-2005**

The health of the South, as measured by death rates for all causes and the three leading causes of death (heart disease, cancer, and cerebrovascular disease) is comparatively worse than in other regions of the country, with the exception of cancer rates.<sup>20</sup> Additionally, suicide rates are also profiled as an indicator of mental health. Morbidity data have been excluded from the analysis due to the difficulty in obtaining county level data for chronic disease indicators.

#### **Mortality Rates, all Causes**

The South generally fares worse than the general population in regard to most leading mortality rates. The overall mortality rate for the U.S. population was 810.6 per 100,000 of the population for the years 2003-2005. The national rate for whites was considerably lower at 796 per 100,000 versus 1,036.1 per 100,000 for U.S. blacks. The overall mortality rate for the South for the same period was 858.3 per 100,000, regionally the highest in the United States. Southern blacks, on the other hand, far exceeded the national average with a rate of 1,072.1 per 100,000.<sup>21</sup> Southern mortality rates for heart disease, cancer, and cerebrovascular disease followed a similar pattern.

#### **Heart Disease Mortality Rates**

The U.S. mortality rate for heart disease, the leading cause of death in America was 220.1 per 100,000. Regionally the South had the highest rate (229.4 per 100,000) in the United States.

In every region of the country, whites maintained lower heart disease mortality rates compared to blacks. In the South, the white mortality rate was 222.1 per 100,000 versus 283.2 per 100,000 for blacks.<sup>22</sup>

### **Cancer Mortality Rates**

The national cancer mortality rate, the second leading cause of death in the United States, was 186.5 per 100,000. For whites, the rate was only slightly lower, 185.2 per 100,000, but for blacks the rate was appreciably higher at 227.7 per 100,000. Regionally, the Midwest had the highest cancer mortality rate in the nation (192.5 per 100,000), followed by the South with a rate of 191.7 per 100,000. Southern blacks had a rate of 231.9 compared to 186.9 per 100,000 for Southern whites.<sup>23</sup>

### **Cerebrovascular Mortality Rates**

The third leading cause of death in the United State is cerebrovascular disease, which includes stroke. The national mortality rate due to cerebrovascular disease was 50.0 per 100,000. The South had the highest rate of all regions (53.7 per 100,000). Southern blacks had the highest rate in the country—77.3 per 100,000. Southern whites, however did not have the highest rate, but rather, the West had the highest mortality rate (51.2 per 100,000) due to cerebrovascular disease.

### **Suicide Rates**

Death by suicide is one health indicator that does not follow the pattern of the leading causes of death. The national rate was 10.9 per 100,000. However, when the data are disaggregated, the suicide rate for the white population was 11.9 per 100,000 compared to 5.3 per 100,000 for U.S. blacks. At the regional level, the West had the highest suicide rate (all persons) (12.4 per 100,000), and the South had the second highest rate (11.7 per 100,000). The same pattern emerged when the data are disaggregated.

## **Diabetes Mortality Rates**

Death due to diabetes is a nationwide health concern as the prevalence rates of diabetes continues to rise. Although an analysis of diabetes was excluded from the case studies (data were not available at the county level), there is evidence that suggests Southerners, and black Southerners in particular, suffer from the highest rates of diabetes in the country (CDC 2005b:483). In a study of the prevalence of stroke, the CDC (2005b) reported that blacks living in the Southeastern United States had a diabetes prevalence rate of 12.1% versus 10.7% for blacks living in non-Southeastern regions of the country. The diabetic disease burden for whites living in the Southeastern U.S. was much less at a rate of 7.6%. Mortality rates, based on 2003-2005 data, draw a more troubling picture. The national death rate due to diabetes was 24.8 per 100,000. White Americans had a rate of 22.6 per 100,000, while the rate for U.S. blacks was more than double at 48.0 per 100,000. At the regional level, the South had the highest rate. Southern blacks had the highest mortality rate in the country, 51.3 per 100,000.

Taken together—sociodemographic, socioeconomic, and health indicators—the population of the South, especially minorities, represents a vulnerable subset of people in the United States. The rural poor of the South in persistent poverty counties are of particular risk, as the case studies will demonstrate. Almost without exception, the indicators reviewed in this chapter are far worse in persistent poverty counties of the South.

Table 2-1. Poverty levels in the South by selected groups, 2006 and 1990: white, black, and Hispanic

Year	White %	Black %	Hispanic %
2006	9.1	23.1	21.5
1990	11.3	31.6	28.1

Source: U.S. Census Bureau 2007i, Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table POV41. Region, Division and Type of Residence—Poverty Status for All People, Family Members and Unrelated Individuals by Family Structure: 2006. Electronic document, [http://pubdb3.census.gov/macro/032007/pov/new41\\_100\\_01.htm](http://pubdb3.census.gov/macro/032007/pov/new41_100_01.htm), accessed March 2008; 1993g: 160-1,164, 1990 Census of Population: Social and Economic Characteristics, United States. Washington, D.C.: U.S. Department of Commerce. Table 136. Summary of Social and Economic Characteristics for White Persons and for Households and Families with a White Householder: 1990; Table 137. Summary of Social and Economic Characteristics for Black Persons and for Households and Families with a Black Householder: 1990; Table 140. Summary of Social and Economic Characteristics for Hispanic Origin Persons and for Households and Families with a Hispanic Origin Householder: 1990.

Table 2-2. Urban versus rural poverty levels in the South by selected groups, 2006: white, black, Hispanic.

White		Black		Hispanic	
Urban %	Rural %	Urban %	Rural %	Urban %	Rural %
7.6	14.7	21.5	30.0	21.8	28.1

Source: U.S. Census Bureau 2007i, Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table POV41. Region, Division and Type of Residence—Poverty Status for All People, Family Members and Unrelated Individuals by Family Structure: 2006.



Figure 2-1. A southern courthouse in Mississippi (Note: Photograph by Susan Morfit, 1994.)

## Notes

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<sup>1</sup> The OECD countries are: Austria, Australia, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, United Kingdom, and United States (OECD 2008b).

<sup>2</sup> Cited health care researchers, with the exception of WHO, refer to developed and industrialized nations interchangeably; however, all are referring to Organisation for Economic Co-operation and Development (OECD) nations. Not all researchers compare all 30 countries. For the most part, the above cited researchers compare the U.S. health care system to countries that maintain universal health care systems.

<sup>3</sup> Each case study will discuss race and racism as it relates to their individual history.

<sup>4</sup> This is the most current official statement.

<sup>5</sup> White and black are racial categories, and Hispanic is an ethnic category.

<sup>6</sup> Just prior to the Civil War (1859), there were ten leading cotton producing states: Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas (U.S. Census Bureau 1969:8-9). For the purposes of this discussion, the Cotton Belt region encompasses all but Florida and Texas.

<sup>7</sup> Data were derived from the Centers for Disease Control and Prevention's (CDC) Wonder data set and were three year averages. Data by race is reported in three categories only: white, black, and other.

<sup>8</sup> The U.S. Census Bureau divides the continental U.S. into four regions: the Northeast, Midwest, West, and South.

<sup>9</sup> Beginning with the 2000 decennial census, the U.S. Census Bureau has changed its public use presentation of data for minorities, eliminating some detailed comparisons. Data for the three largest groups are not available for the comparable variables used for the 1990 decennial census for the case studies.

<sup>10</sup> Before examining rural poverty patterns, a note about the terms of rural/urban and metropolitan/nonmetropolitan is useful. These terms are official federal agency definitions that are somewhat contrasting. The U.S. Census Bureau uses the terms urban and rural based on population densities as well as the terms metropolitan (metro) and nonmetropolitan (nonmetro) which measures the degree of urban and rural patterns for every county in the United States based on a numeric coding system: 0 to 3 measure levels of urbaneness and 4 to 9 measure levels of rurality, commonly referred to as the Rural-Urban Continuum Codes (USDA 2001d). In conjunction with the Rural-Urban Continuum Codes, the USAD applies the codes to nonmetro counties (1) non-overlapping categories of farming, mining, manufacturing, government, services, and nonspecialized and, (2) overlapping policy categories of retirement, federal lands, commuting, persistent poverty, and transfers. The ideology behind the coding was to provide a more specific description of counties for federal policy decision making (see Cook and Mizer 1994).

<sup>11</sup> Under the U.S. Census Bureau's six definitions of rural, the percentage of the U.S. population designated as rural fluctuates from 21% to 63%; under USDA's two definitions of rural 20% to 36% of the population is deemed rural; and under the most restrictive definition of rural, as supported by the president, only 17% of the U.S. population is considered rural (USDA 2007).

<sup>12</sup> Only the Bebé Sano program would qualify as rural research by OMB's 2006 definition. The primary counties for West Alabama Health Services (Greene County, Alabama) and Children and Family Services (Tipton) are now designated as metropolitan. Tipton County was coded as a metropolitan county in 1990, but was included in the study because two of the counties served by the agency were designated as persistent poverty counties. By USDA's latest county policy designations, none of the counties in Children and Family Services' catchment area are persistent poverty counties (USDA 2007).

<sup>13</sup> The latest data available by region and ethnicity rural for per capita incomes, unemployment, and educational attainment are derived from the U.S. Census Bureau, 2006 American Community Survey (ACU) (U.S. Census

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Bureau 2008). The ACU does not provide data by region, urban versus rural, and by ethnicity that is, there are no comparisons of regional urban-rural with regard to ethnicity.

<sup>14</sup> Comparison of per capita incomes between 2006 and 1990 have been excluded from the analysis since the data is not adjusted for inflation and the dollar values are not comparable.

<sup>15</sup> The black unemployment rates for the four regions ran from 11% to 16.4%, while the Hispanic unemployment rates ranged from 6.8% to 8.7%. The Hispanic unemployment rate was highest in the Northeast and the lowest in the South. The lowest black unemployment rate was in the West.

<sup>16</sup> Educational attainment in this context is measured by the U.S. Census Bureau as a percentage of the population 25 years or older with a high school diploma, or its equivalent, or higher (U.S. Census Bureau 2003:1). Computation of Hispanic educational attainment began in 1974 (U.S. Census Bureau 2007j).

<sup>17</sup> Related to the relative numbers of Medicare recipients, in the rural South is the level of reimbursement that is paid for services under the program. Traditionally, cost reimbursement for Medicare has been disproportionately lower in the South than other regions of the country and even lower for rural areas as compared to urban areas (see Nycz and Schmelzer 1992 for an in-depth discussion of Medicare payment distribution). Mueller et al. (1999) ascribe this payment discrimination to the misconception that services rendered in rural regions are less costly than in urban locales (see also, Ricketts 2000:646). With the advent of the Balanced Budget Act of 1997 this rural/urban inequity was addressed through a new payment methodology which has improved the payment distribution somewhat, but inequities are predicted to continue “with rural payment rates remaining consistently lower than urban payment rates” (Mueller et al. 1999:79-82).

<sup>18</sup> According to the National Rural Health Association (1999:3; see also, Pol 2000; Schur and Franco 1999), this pattern is exaggerated in the rural regions and is due to more than just gross poverty levels, but is exacerbated by employment situations (where insurance coverage is more limited, e.g., working for a small business or employment in agricultural based work) and national trends (e.g. escalating health insurance premiums and decreasing coverage of dependants by employers).

<sup>19</sup> Peggy Cook (2000) suggests that a robust economy in the 1990s coupled with changes enacted through welfare reform in 1996 contributed to a decline in Medicaid roles and other welfare programs. However, since 1999, the national Medicaid roles have increased considerably. In 1992, for example, 10.3% of the U.S. population was enrolled under Medicaid, by 2006 the number had risen to 12.9% (U.S. Census Bureau 2007k; U.S. Census Bureau 2007h).

<sup>20</sup> All 2003-2005 mortality rates are age adjusted, three-year averages per 100,000 population and are based on ICD-10 codes (CDC 2008).

<sup>21</sup> Regionally, the Midwest blacks had the highest mortality rate (1,091.4) slightly higher than Southern blacks (1,072.1).

<sup>22</sup> Again, Midwest blacks had a higher heart disease rate (303.4) than Southern blacks (283.2).

<sup>23</sup> Again, Midwest blacks had a higher cancer rate (247.1) than Southern blacks (231.9).

## CHAPTER 3 FEDERAL POLICIES, EXECUTIVE AGENCIES, AND PROGRAMS

### **Introduction**

Prominent national-level forces greatly impact the health of Americans in the rural South and are basic elements of our society. These forces include politics, economics, and institutionalized racism. They permeate and saturate laws and policies governing health services at all levels of government. Underpinning the health system in the impoverished rural South, I will argue, are dominant federal policies and executive agencies that pervasively influence how health care is provided at the community level, often leaving the rural poor and their health care practitioners relatively powerless to control their own future. Specifically, health care for the impoverished in the rural South is intrinsically linked to the national health policy process and is reflected through sociodemographic, socioeconomic, and health outcome indicators as discussed in Chapter 2.

The delivery of health care in the rural southeastern United States is influenced by a number of structural forces at the federal, state, and local level within each of the rings in the theoretical model. These structural forces encompass health policy, financing, health care resources, institutions, organizations, poverty, and race and ethnicity to name only a few of the more entrenched and obvious, yet at times, transparent and invisible forces. They originate at all political levels, but national level concerns have an overarching influence and often eclipse forces at other political levels. The delivery of health care in the rural Southeast must thus be viewed within the larger geopolitical milieu of which it is part, with specific consideration of health care in relation to the national political system and the overall U.S. health care system.

## **National Forces and the Health Policy Process**

The federal government has greatly influenced health policy since the mid-19th century (Table 3-1). Previously, health care policy rested in the domain of the states and the medical community. With the passage of decades of health legislation, the federal government has become the most powerful conduit in the health care policy process. As defined for the purposes of this work, the health care policy process is the recognition of a health problem (genesis), its transformation to law, subsequent implementation, and its temporal transformation. The process will be illustrated through a series of examples. The United States legislative structure, a critical macro structure directing health policy, is a convenient starting point in the contextualization of the process.

### **National Legislative Structure**

Fundamental to the U.S. political system is the constitutional separation of powers. This constitutional delineation provides checks and balances for the three branches of government: executive, legislative, and judicial (Litman 1997:7, 11). At the macro level, the legislative branch is composed of Congress, which is divided into two chambers, the Senate and the House of Representatives. Congress has the constitutional responsibility to establish public law, monitor federal agencies, and allocate funds for federal programs. The legislative process is complicated and arduous. It is based on negotiation and compromise and one that does not allow for easy passage or reforms of public laws (see Litman 1997; Falcone and Hartwig 1997 for an in depth account). Yet, many major changes to the United States health care system have occurred through the federal legislative process (Table 3-1). Even legislation that is not written to address health issues specifically may have dramatic influence on health care policy, for example, the 1960s Civil Rights legislation.

### **Genesis of health initiatives: Illustration from the executive office**

More important to the topic under discussion is the genesis of health care legislative initiatives. Legislative initiatives can be proposed by members of Congress, the President (the executive office), and by organizations, individuals, special interest groups, and through direct lobbying to Congress, to name only a few. However, according to Falcone and Hartwig (1997:141), in the last twenty years the responsibility has shifted significantly to the executive branch. The office of the President has the power to propose, lobby, and veto legislation at the discretion of the President. As a rule, Presidents come to office with legislative agendas already formulated by their presidential candidate platforms (see Lammers 1997 for a detailed account of presidential leadership in policy formation). For example, in the presidential campaign of 2000 between Al Gore and George W. Bush; both candidates campaigned to provide prescription drugs to Medicare recipients. However, to make that campaign promise a reality, President Bush submitted a legislative bill to Congress and was passed by a majority vote before becoming a law (Medicare Modernization Act) in December 2003 (Kaiser Family Foundation 2008a). In other cases, groups or individuals can petition (lobby) the president directly to initiate legislation on their behalf.

### **Changing the rules: special interest groups transmuting health care policy**

The transition from one presidential administration to the next is an opportunity to examine how health care policy is transmuted by politics. On Sunday, February 25, 2001, The New York Times reported that the National Governor's Association and the National Association of State Medicaid Directors "... have convinced the new administration that [the new] Medicaid rules are flawed and should be reconsidered . . ." (Pear 2001). The headline reads "States ask Bush to revoke Clinton's Medicaid rules" that were, according to the article, "issued in the final hours of the Clinton administration." These two associations, wasting little time (the new administration

had been in office for barely more than a month), were lobbying President Bush to use his executive powers to change the language of a law passed in 1997, the Balanced Budget Act of 1997 (HHS 2001a). In this law, provisions were made to extend a “Patients’ Bill of Rights” to persons enrolled in Medicaid managed care programs referred to as the “Medicaid Managed Care Rule” (HHS 2001a). In order to understand why the governors and the Medicaid directors waited until this particular point in time to lobby the President for changes in legislation passed by Congress in 1997, it is helpful to understand the process of policy: from recognition of a health care issue, to becoming a public law, to its implementation.

### **Participatory democracy and policy process**

The two associations cited above (the National Governor’s Association and the National Association of State Medicaid Directors) and their efforts to persuade President Bush to make changes in a health policy implemented by President Clinton are an excellent examples of participatory democracy, another main element of the U.S. political system. Participatory democracy can be broadly described as public involvement in the making of policy decisions at all levels of the policy process (Litman 1997:20-21). This “public involvement” can be by individuals, but, more commonly, it is achieved through groups referred to as special interest groups or political action committees, such as the National Governor’s Association and the National Association of State Medicaid Directors. As Litman points out, “the efforts of organized interest groups to influence government policy in the United States are an inherent part of the political process and, in large measure, rest on First Amendment guarantees of free speech and the people’s right to petition government for a redress of grievances” (Litman 1997:15). The governors and state Medicaid directors were doing just that.

Usually, special interest groups seek to influence government policy at the Congressional level before it is passed into law, but if that strategy fails, groups may continue to effect policy

through the federal agency charged with implementing the policy. In the case of the Medicaid Managed Care Rule, an executive agency of the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), was in charge of writing the regulations for the Medicaid Managed Care Rule, and, in doing so, CMS had to post the proposed regulations in the Federal Register for public comment, which it did in 1998. However, the New York Times article (Pear 2001) reported that, “after the rules were proposed in September 1998, the National Governor’s Association submitted lengthy comments to the Department of Health and Human Services. However, according to Matt D. Salo, then Director of Health Legislation for the governor’s association, ‘Ninety-nine percent of our comments were ignored’” (Pear 2001). On Thursday, January 18, 2001, only two days before President Bush took the oath of office—and more than three years after the legislation was passed—HHS announced the final regulation for the Medicaid Managed Care Rule (see HHS 2001a). Failing to influence the agency in charge of implementing the policy, the governors and state Medicaid directors took their appeal to the new administration with some success (Pear 2001).

But why appeal to the new president at this particular point in time? First, President Bush was very well aware of the concerns of the governors and the Medicaid directors, as he had just left the office of governor of Texas. Second, he had the executive power to enact change: it was his executive agency, Health and Human Services (HHS), which would be tasked with rewriting the Medicaid Managed Care Rule. Third, President Bush had just appointed the former Republican governor of Wisconsin, Tommy Thompson, to the post of Secretary of Health in charge of HHS. In this position Secretary Thompson was answerable to the President (served at the discretion of the President) and, given his political background as former Governor of Wisconsin, he would have been more sympathetic to the lobbyists’ requests. Last, the two

groups clearly saw what John Kingdon (1995:212) refers to as a “window of opportunity” to press their case with the president. Seventeen days before The New York Times (Pear 2001) story was published, President Bush (2001) wrote a letter to the Congressional Democratic Congress regarding his position on a “Bipartisan Patients’ Bill of Rights.” in protecting enrollees in HMO plans. In that letter, dated February 7, 2001, President Bush presented his “principles” for such a bill and stated, “I look forward to working with you and all Members of Congress to enact these principles into law as soon as possible” (Bush 2001). Considering the context in which the governors and state Medicaid directors made their requests, they certainly perceived the President’s policy stand as an open window to advance their case.

### **Transmuting health laws through the judicial system**

Once Congress has passed a law and it has been implemented, another avenue to effect policy is through the courts. An appropriate case in point is the judicial intervention in how Texas managed its Medicaid program. At present, the states “have rather broad, comprehensive legal authority” (Litman 1997:26) in managing their Medicaid programs; however, the states have certain restrictions or guidelines set forth by the federal government which must be adhered to in administering their Medicaid programs.

In the case of Texas, while President George W. Bush was governor of Texas, he faced “accusations of striking inadequacies in the state’s health care for the poor and uninsured children” (Oppel 2000). Concerned citizens filed a class-action lawsuit on behalf of Medicaid eligible children. The governor, according to the class-action lawsuit, failed to properly administer the program; thus, the issue was addressed through the federal judiciary system. According to Oppel (2000:A14), approximately half a million children in Texas lacked health insurance coverage and at least 600,000 more were eligible for Medicaid services. The federal court, in response to the 1993 law suit, issued a consent decree in 1996 aimed at improving the

program. However, the state did not meet the requirements as stipulated in the consent decree; thus the attorneys for the children returned to federal court in 2000 arguing “the state was not living up to the decree” (Oppel 2000:A14). Federal District Court Judge William Wayne, as a result, filed a ruling August 14, 2000 stating, in part, Texas’ Medicaid program serving poor children was “badly flawed,” and the governor was again ordered to improve the program. This ruling was the latest in a round of judicial proceedings stemming from the class-action law suit. The process of addressing the egregious issues brought against the state in 1993 on behalf of its children, demonstrates how health policy can be amended or reinterpreted. This case in point demonstrates the separation of powers and the U.S. federal system of checks and balances in action (see Litman 1997).

### **Health Care Policy Implementation: The Department of Health and Human Services**

Second only to the legislative process, Health and Human Services (HHS) is the most influential political entity in shaping national health policy in the country. It is through HHS that all national health laws are implemented. HHS consists of eleven agencies (Table 3-2) and is headed by the presidentially appointed Secretary of Health and Human Services. Among the eleven HHS agencies there are two agencies in particular that have a tremendous impact on the delivery of health care services for the nation. They are, Centers for Medicare and Medicaid Services (CMS), and Health Resources and Services Administration (HRSA). Before discussing these agencies in more detail, it may be advantageous to briefly describe the payment structure of the U.S. health care system.

### **United States Health Care Payment Structure**

Unlike most industrialized countries where health care is provided by the government as a national system with universal coverage for all persons, the U.S. health care delivery system is a combination of private and government health insurance based on a free market enterprise

(Davis et al. 2007; Iglehart 1992; Litman 1997:28; Nottle and McKee 2008). And yet, in spite of the free market competition, the U.S. health care system is the most costly in the world whether measured as health expenditures per capita or as a percentage of the gross domestic product (GDP) (Cylus and Anderson 2007:18). The per capita public health care expenditures were greater than the private health care expenditures in the United States, and Americans spent more for out-of-pocket expenses than citizens of other industrialized nations (Cylus and Anderson 2007:20). According to the World Health Organization (WHO), the United States spent 15.2% of the GDP on health, more than any other industrialized nation (WHO 2008).<sup>1</sup>

There have been many attempts to pass legislation for universal health care, beginning as early as 1912 with the Theodore Roosevelt presidential campaign (Table 3-3) (Weeks and Berman 1985:50). By 1927, a group of scholars from the medical and social sciences formed a committee, the Committee on the Costs of Medical Care, to conduct a five year study on the economic aspects of health care delivery in the United States (Weeks and Berman 1985:9-25, 269-276).<sup>2</sup> The committee produced 27 volumes of studies and recommended “group payment to defray the costs of medical care through an insurance plan, through taxation, or through a combination of those methods” (Weeks and Berman 1985:273).<sup>3</sup> The final report, released in October, 1932, was not received well by the American Medical Association (AMA). An editorial published in the Journal of American Medical Association declared the report was “Socialism and Communism—inciting to revolution” (Weeks and Berman 1985:20). A member of the committee said that comment served to “set the dominant ideological” national conscious; “anyone who advocated national health insurance was usually tarred with the epithet of being a socialist or a communist, or a radical” (Weeks and Berman 1985:21). It ultimately took 33 years to pass a limited version of the committee’s recommendation for universal health coverage

through Medicare and Medicaid. As a result of more than half a decade of political compromise, the U.S. health care coverage is characterized by (1) private sector health insurance (most often employment based); (2) government funded health insurance at various geopolitical levels, also referred to as the public sector health insurance; and (3) the uninsured.

Health economist Robert Evans (1997) optimistically reported as of 1991 that the majority, 71%, of the people in the United States relied on private insurance to cover the costs of health care. The widespread use of employment based private insurance may lead one to think that those insured by private insurance decrease the economic burden on the federal government. However, the true costs covered by private insurance are lower than one might expect since private insurers “avoid offering coverage to people in poor health or otherwise at high risk, and they place a variety of limitations on the coverage they do offer” (Evans 1997:266), or in the words of Enthoven and Kronick, “insurers profit most by avoiding coverage of those who need it most” (Enthoven and Kronick 1997:327). The costs for health care for those persons with poor health or at high risk are shifted to the public (government) sector. Evans estimates the public sector accounts for approximately 44% (as of 1993) of all health care expenditures in the United States. However, in reality that percentage is much higher when one calculates the amount of tax revenue the government loses on private health insurance—“the premiums are deductible from the employer’s taxable income, but not taxed as income in the hands of the employees” (Evans 1997:266). Evans considers these nontaxable health insurance benefits a public subsidy, which are worth \$75 billion in lost government tax revenue and represent a total of eight percent of all health expenditures for fiscal year 1994. Private health insurance coverage has abruptly declined since 1991, however. At its peak in 2000, the percentage of the population covered by private health insurance was 72.6—by 2006 only 67.9% were covered (U.S. Census Bureau 2007a).

Over a fourth of the U.S. population was covered by government insurance by 2006, leaving nearly 47 million people uninsured (U.S. Census Bureau 2007b).

### **National Policies, National Health Care Programs, and National Health Care Funding**

The federal government's role in health care dramatically expanded in the second half of the twentieth century, with the initiation of Medicare and Medicaid in 1965. As stated above, the U.S. Department of Health and Human Services (HHS) is the government agency which coordinates most of the federal health initiatives with the exception of the Armed Services and the Veterans Association federal programs which provide health care to military personnel and military veterans respectively. HHS is comprised of 11 agencies, had an annual budget of \$697.5 billion (fiscal year 2007), and employed 66,890 persons (HHS 2007a). Of the eleven agencies eight are U.S. Public Health Service agencies: National Institutes of Health (NIH), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and Agency for Healthcare Research and Quality. Other HHS agencies include, Centers for Medicare and Medicaid (CMS), Administration for Children and Families (ACF), Administration on Aging (AOA) (Table 3-2). CMS and HRSA are the primary agencies directly involved in providing health care to the nation.

#### **Center for Medicare and Medicaid Services**

The Centers for Medicare and Medicaid Services budget (fiscal year 2007) was \$569.8 billion and employed 4,538 people (HHS 2007b). In June 2001, the Secretary of HHS, Thompson, changed the name of the agency from Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). The change in the agency's

name from its original name was symbolic of the “restructuring” of the agency after President Bush took office. The agency administers three prominent programs under the Social Security Act: Medicare (Title XVIII), Medicaid (Title XIX), and the State Child Health Insurance Program (Title XXI).

## **Medicare**

President Lyndon Johnson on July 30, 1965 signed Medicare into law as an amendment to the Social Security Act under Title XVIII (CMS 2007a). Medicare is the nation’s largest health insurance plan insuring over 40 million people and is administered and paid for exclusively by the federal government. The program provides health insurance for three groups of people (1) people 65 years or over and who are eligible for retirement benefits (that is, if they or their spouse has worked for 40 or more quarters of Medicare covered employment, otherwise the premiums are \$300 per month); (2) people who are disabled, and (3) people with permanent renal failure (HCFA 2001a:2-3; 2001b:1). The Medicare program consists of four parts: hospital insurance, Part A; medical insurance, Part B; Medicare Advantage Plan an alternative health insurance program, Part C; and prescription drug program, Part D (CMS 2007b). Part A is funded by Medicare Trust Fund through a designated tax paid by American workers (Ricketts III 1999:63). Part B of the program is funded separately from Part A as a voluntary insurance program funded by monthly premiums paid by eligible individuals; it pays for physicians’ services, outpatient hospital services, medical equipment and supplies as well as other health services (CMS 2007b:7). Part C is primarily a HMO type insurance plan funded through beneficiary monthly premiums. The plan is relatively new beginning in 2006. Part D is the prescription drug plan that also began in 2006 and is funded through monthly premiums. CMS writes all guidelines for the program, directly contracts with insurance companies for Medicare coverage, and is the largest institutional buyer of health care in the country (Litman 1997:55).

The cost of Part A and Part B of the program cost the federal government 354.9 billion in 2006 (CMS 2007b:6-7).

## **Medicaid**

Medicaid was established through legislation in 1965 under President Johnson's administration (see Lammers 1997:119-121) at the same time as Medicare. Like Medicare, it is also a health insurance program. However, unlike the Medicare program, the Medicaid program is a joint venture between the federal government and the states, and its target beneficiaries are "certain low-income families with children; aged, blind, or disabled people on Supplemental Security Income; certain low-income pregnant women and children; and people with very high medical bills" (HCFA 2001:3). According to the U.S. Census Bureau (2007h), in 2006 the program provided services to over 38 million people and is paid for jointly by the federal government and the states through matching funds. The federal government provides funds ranging from 50% to 83% of total costs based on the relative per capita income of the states (CMS 2007b:21; Ricketts 1999:63). The Medicaid program cost the federal and state governments an estimated \$319.6 billion, for fiscal year 2006 (CMS 2007b:23). All states must comply with certain requirements mandated by the federal government. However, the states design and administer their programs providing the federal government with annual reports. The states directly report to CMS, the HHS agency that provides oversight for all Medicaid programs. Among the federally mandated requirements, all states must provide the following basic services: hospital services (inpatient and outpatient), laboratory and x-ray services, skilled nursing and home health services, doctors' services, family planning, periodic checkups, diagnosis and treatment for children. Nevertheless, the states have the authority to establish eligibility standards and set payment rates (CMS 2007b). However, most states have more control of the design of their Medicaid programs through waivers (Section 1115 Waivers). The

Section 1115 Waivers were designed to allow the states to bypass federally mandated regulations to some degree and to give states the autonomy to design managed care programs (Slifkin and Casey 1999:95). Tennessee was one of the first states to design a Medicaid Managed Care program for its total Medicaid population under the Section 1115 Waiver; it began on January 1, 1994 (Gold, Frazer, and Schoen 1995).

In 2005, Congress passed the Deficit Reduction Act that redefined Medicaid eligibility requirements, added premium and co-pay options, and elders seeking to enroll in long-term care face new restrictions (Kaiser Family Foundation 2006). Undocumented immigrants, under the new law, no longer have access to Medicaid services for routine care. The law requires all new enrollees to provide proof of U.S. citizenship as of July 1, 2006 (CMS 2007b:19; Kaiser Family Foundation 2006:5).<sup>4</sup> Under the new provisions of the Deficit Reduction Act, states have the option for the first time to charge all beneficiaries premiums and higher co-pays. The law also allows states to enforce such charges by denying services to individuals whom cannot pay at time of service. Furthermore, states can terminate enrollees for nonpayment of premiums after sixty days (Kaiser Family Foundation 2006:2). Elderly persons applying for long-term care under Medicaid and who have home equity of \$500,000 or more are disqualified from long-term care under Medicaid (CMS 2007b:19). Furthermore, elder individuals who transfer assets to qualify for long-term care face an extended “look-back” period from three to five years (Kaiser Family Foundation 2006:4).<sup>5</sup>

### **State Children’s Health Insurance Program (SCHIP)**

State Children’s Health Insurance Program is a program that was established under the Clinton administration in 1997 through the legislation of the Balanced Budget Act of 1997 (amended the Social Security Act, Public Law 105-33) (U.S. Congress 1997), and is jointly run by CMS and HRSA (HCFA 2001c). The federal government provides matching funds to states

for program benefits. In 2007 SCHIP insured over six million children, leaving another nine million children uninsured (Kaiser Family Foundation 2007b). Like Medicaid, the states must provide specific coverage benefits (basic services), but have the freedom to design their own programs. However, states may use the funds to expand Medicaid eligibility (HCFA 2001c:8).

Congressional allocations for this program included \$4.275 billion for fiscal years 1998-2001 and \$3.15 billion for fiscal years 2002-2004 (HCFA 2001c:3). Eligible children include those not eligible for Medicaid and who reside in a low-income family. Eleven states have authorized pregnant women not eligible for Medicaid to participate in their SCHIP programs (Kaiser Family Foundation 2007b). Legislative authorization for the program has been extended but the long term forecast remains cloudy. Emergency funding through a “Continuing Resolution” was passed by Congress to provide funding through November 16, 2007 (Kaiser Family Foundation 2007b). The reauthorization bill, the Children’s Health Insurance Program Reauthorization Act of 2007 (CHIPRA), was passed by Congress and vetoed by the President October 3, 2007 (Kaiser Family Foundation 2007b, 2008b; Pear and Stolberg 2007). The Congress again passed a reauthorization bill, which was again vetoed by the president in December 2007 (Kaiser Family Foundation 2008b). Finally, in late December, Congress passed and the president signed the Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110-173, continuing the program at essentially current funding levels through FY 2009 (Kaiser Family Foundation 2008b). Whether Congress will take up the reauthorization measure again in 2009 is yet to be determined.

CMS, in addition to administering these three programs, regulates laboratory testing, provides assistance to small businesses in acquiring health insurance coverage, and helps to eliminate discrimination based on health status for people purchasing health insurance (HCFA

2001:1). The agency's employees are engaged in other activities as well such as, policy development, legislative analysis and liaison duties, health care research, data collection and processing, and enforcement of health care quality standards (HCFA 1997).

### **Health Resources and Services Administration (HRSA)**

HRSA, one of the Public Health Services agencies, provides an array of health care programs, has an annual budget of \$6.4 billion (fiscal year 2007), and employs 1,600 people (HRSA 2007a). The primary mission of HRSA is to provide primary health care to medically underserved populations and vulnerable populations such as low income women and their children, people living with HIV/AIDS, homeless, and migrant farmworkers. More broadly, the mission statement of HRSA is to “[direct] national health programs that improve the Nation’s health by assuring equitable access to comprehensive, quality health care for all” (HRSA 2001a:1). It is within HRSA that the Community Health Centers program is administered, and is referred to as the nation’s health care safety net (HRSA 2008a:25). Like CMS, HRSA has undergone a “restructuring” since the change in the Presidential administration in 2000.

Three divisions within HRSA that coordinate funding of programs for vulnerable populations are of particular note for the purposes of the dissertation. They are, the Office of Rural Health Policy (ORHP), the Bureau of Primary Health Care (BPHC) and the Maternal and Child Health Bureau (MCHB). These divisions contribute to the health and welfare of the nation, and are critical for rural America. However, under the Bush administration, two of the three divisions have endured severe budget cuts.

### **The Office of Rural Health Policy (ORHP)**

ORHP plays a significant role in rural health. The office was established 1987, two years after HRSA was created, by Congressional legislation to assist the Secretary of Health and Human Services on rural health issues and effects of current policies and proposed legislation

(HHS 2008c). Some of the issues under the purview of the ORHP include: the viability of rural hospitals, recruitment and retention of health professionals, and access to health care in rural areas (Social Security Act, Section 711 [42 U.S. C. 912]). However, as a result of recent budget cuts, the mission of the Office has changed: the ORHP no longer provides grants to states and local communities for rural health care programs and infrastructure.<sup>6</sup> The ORHP also provides support to selected universities for research on rural health issues.

At the time I conducted my internship there in the summer of 2001, the ORHP supported several university-based research institutions. The role of the institutions was to provide the office the latest rural health research to inform the Secretary of Health and Human Services and Congress on all issues concerning rural health. ORHP worked closely with the research institutions on all Congressional rural health initiatives. Observing the relationships between the research institutions and ORHP, I was able to observe the intricate negotiations as health policies navigated the legislative process. Rural health special interest groups were continually lobbying Congress, at times, with the assistance of ORHP. The relationships between rural health advocates, the health care research institutions, ORHP, and Congress are complex and powerful. ORHP serves the President, but it also serves rural constituents.

For example, when the newly appointed Secretary of Health and Human Services took office, he toured each of the HHS agencies (an act that surprised many at HRSA because it is very unusual for the Secretary of Health to do so). When he toured HRSA, he toured each of the Bureaus and Offices meeting with directors and staff, it was an opportunity for directors to press their agendas however fleeting the time with him. The director of ORHP was very effective in impressing on the Secretary the plight of rural Americans. The Secretary empathized with the rural issues stating he came from a rural state and realized the needs first hand and that more

should be done for them. It was an opportunity to watch how health policy is transmuted by “the window of opportunity.”

### **Bureau of Primary Health Care (BPHC)**

The Bureau of Primary Health Care is the second largest bureau within HRSA. BPHC plays a critical role in the nation’s health care safety net through a vast network of primary health programs such as, U.S.-Mexico Border Health Program, Community Health Centers (CHC), Health Care for Homeless Program, and Migrant Health Centers, to name only a few.<sup>7</sup> The majority of the BPHC’s budget (\$1.16 billion) is devoted to providing assistance to health centers through the Community Health Center Program, administered by the BPHC as established by Public Law 104-299 (HHS 2007d).

Community Health Center and Migrant Health Center programs were established in the 1970s under the authority of the U.S. Public Health Services Act (HHS 2008c). In 1996, BPHC’s four health center programs, CHC, migrant health centers, health care centers for the homeless and public housing health centers were consolidated under one umbrella program (Health Centers Consolidation Act of 1996, Public Law 104-299. The CHC program provides grants to states and communities for preventive and primary health care services (HHS 2007d). The BPHC funds primary health care centers in urban and rural medically underserved areas where economic, geographical, or cultural barriers restrict access to primary health care for a substantial segment of the population (HHS 2001b:1). In 2007, BPHC funded approximately 1,200 grantees operating 6,000 delivery sites serving 16 million people, all of whom were from medically underserved areas (Bohrer 2001; HHS 2008c:2-3). Over 90% of the patients were composed of whites (36.3%), Hispanics (36.1%), and blacks (23.0%) (HHS 2008c:5). The majority of the patients (82%) were either uninsured (39%), covered by Medicaid (35%) or

Medicare (eight percent) (HHS 2008c:4). That is, nationwide over seven of out ten CHC patients were either uninsured or covered by Medicaid.

In 2007, migrant health centers served 826,639 migrant farmworkers; the majority (92 percent) was Hispanic (HHS 2007f, 2008c:7). Since 1998, a BPHC policy, Policy Information Notice 98-23, requires that community health centers that serve a culturally diverse catchment area must provide “a culturally and linguistically appropriate staff” (National Center for Cultural Competence 2008a:2). In addition to the nondiscrimination requirements listed in Title VI of the Civil Rights Act of 1964, this policy requires CHCs to provide primary care treatment regardless of the patient’s ability to pay, and proscribes discrimination on the basis of “language, gender, socioeconomic status, housing status or regional differences” (National Center for Cultural Competence 2008a:2). BPHC policy recommends that the CHCs participate actively in the culturally diverse community, and provide services that are appropriate to the cultural sensitivities of the community with staff who are able to communicate effectively in the patient’s primary language (National Center for Cultural Competence 2008a).

The demographics for community health centers in Alabama and Tennessee were considerably different than the national profile. Community health centers in Alabama (2006) served nearly 300,000 people: 54% were black, 35.8% were white, and seven percent were Hispanic. Nearly half (49.9%) of the patients were uninsured, 27.4% were covered by Medicaid, and 9.3% were covered by Medicare (HHS 2007g). In Tennessee, community health centers served over 270,000 residents: 62.9% were white, 26.1% were black, and 8.8% were Hispanic. The uninsured accounted for 38.5% of the patients, 34.3 were covered by Medicaid, and 10.3% were covered by Medicare. In Tennessee, just under four thousand CHC patients were migrant farmworkers (HHS 2007h).

Community health centers continue to have the support of the present administration. Federally supported community health centers, as federal rhetoric reminds the public, are an essential part of the nation's health care safety net (HHS 2002; HHS 2007c). When former Secretary Thompson joined President Bush's Cabinet as Secretary of Health and Human Services, the provision of rural health care through community health centers caught his attention. Secretary Thompson made improvements in access to health care through the expansion of community health centers one of his top priorities. President Bush embraced the Secretary's vision and made it one of his health care policy priorities to continue the expansion of the CHC system (HHS 2007c). Known as "President Bush's High Poverty County Initiative," and announced in the 2005 State of the Union Address, the new initiative reinvents policy (HHS 2007c). The newly formulated policy draws attention away from the most impoverished to a wider configuration of poverty—away from persistent poverty counties to any non-metro county with a poverty rate of 20% or higher. Nearly half of the 444 counties are identified as black counties (210) and are clustered in the South (Beale 2004:23).

### **Maternal and Child Health Bureau (MCHB)**

The Maternal and Child Health Bureau provides monies to states and communities expressly targeting mothers and their children. The genesis of the bureau came from the passage of Congressional legislation dating back to 1935: the Social Security Act of 1935, an Act that included Title V which established The Maternal and Child Health Services. The Maternal and Child Health Services morphed into MCHB under the guidance of HRSA. Maternal and Child Health Block Grants receive the largest portion of the bureau's budget. Other programs administered by the bureau are: Traumatic Brain Injury, Sickle Cell Service Demonstration, Universal Newborn Hearing, Healthy Start, Emergency Medical Services for Children, Trauma Emergency Medical Services, Poison Control Centers, and Family to Family Health Information

Centers (HHS 2007b:31). The bureau's FY 2008 budget was \$666,155,000 down nearly \$64 million from FY 2004 (HRSA 2008b). The funds for this program are allocated directly to the states through the provision of block grants in support of maternal and child health programs and services following a federal agenda of services. One important stipulation to the block grants is that states must use 30% of the allocated funds for "children with special needs" (HRSA 2001a). In addition, the states also are required to match three out of four federal dollars allocated under the block grant (HRSA 2001b:2).

In comparison to the Maternal and Child Health Services program, the Healthy Start Initiative was the second-highest funded program in MCHB in 2008, receiving approximately 15% (\$99,744,000) of the MCHB budget (HRSA 2008b). The Healthy Start Initiative (a categorical program) funds the development of initiatives and programs specifically targeting the reduction of infant mortality in high-risk communities (HRSA 2001a:2).

The Maternal and Child Health Services' programs dovetail with Medicaid and the U.S. Department of Agriculture's (USDA) program providing federal grants to states for the Special Supplemental Nutrition Program for Women and Infant Children (WIC). The WIC program provides low-income women and their children under the age of five (and who are at nutritional risk) with supplemental foods, education on nutrition, and referrals for access to health care (USDA 2001; see also, Child Nutritional Act of 1966 [as amended through Public Law 106-224, June 20, 2000]).

Title V programs are intrinsically linked to Medicaid services and SCHIP (e.g., in the South 75.1% [based on 1998 figures] of the pregnant women served by Title V programs were Medicaid recipients [MCHB 2001b:3]). MCHB's programs directly impact, augment, and are

integral to state and local health care delivery services for mothers and their children. They are especially critical in providing services to those persons without insurance coverage.

### **In Summary**

This chapter provides a brief outline of the germane federal legislation and policies, executive agency involvements, and program structure and operation related to this dissertation. Within the scope of the theoretical model, these federal forces interact in a complex network intertwined with forces at other governmental and social levels, but remain the dominant determinates of structure and viability for health programs serving rural poor populations in the South. The following case studies provide specific and detailed insight into the implementation and operation of federal programs at the community level.

Table 3-1. Historical review of major health policy legislation passed by Congress.

1921-1929	Shepard-Towner Act	Provided funding for maternal-child health Provided federal grants to states for public, maternal-child health (Title V), and crippled children
1935	Social Security Act	Provided health care to low income farmers, sharecroppers, migrant farmworkers
1935-1947	Farm Security Administration	Legislative authorization of present-day HHS
1944	Public Health Service Act	Provided monies for hospital construction (physical plant improvements)
1946	Hill-Burton Construction Act	Provided federal funding for clinics for migrant and seasonal farmworkers, evolved into the Community Health Centers, Public Law 87-692
1962	Migrant Health Act	Provided health care to elderly (Title XVIII) and (XIX) low income populations through amendments to the Social Security Act
1965	Medicare and Medicaid	Authorized the women, infant and children (WIC) supplemental nutrition program, Public Law 89-642
1966	Child and Nutrition Act of 1966	Provided expansion of Rural Health Centers and Community Health Centers under the Public Health Service Act
1972	Rural Development Act of 1972	Provided health care access to rural residents, Public Law 95-210
1977	Rural Health Clinics	Consolidated Community Health Centers, Migrant Health Centers, Homeless Health Centers, and Public Health Centers, Public Law 104-299
1996	Health Centers Consolidation Act of 1996	Provided an amendment to the Social Security Act to establish the State Children's Health Insurance Program under Title XXI (SCHIP), Public Law 105-32
1997	Balanced Budget Act of 1997	Provided prescription drug coverage to Medicare, Public Law 108-173
2003	Medicare Modernization Act	Provided states with funds to establish a comprehensive system of early intervention services for infants and toddlers with disabilities, Public Law 108-446
2004	Individuals with Disabilities Education Improvement Act of 2004	Required proof of citizenship for new enrollees (2006); allowed states to set premiums for all beneficiaries, Public Law 109-171
2005	Deficit Reduction Act of 2005	

Sources: Litman 1997:22-24; HEW1976:1-2; Johnson 1985:141-143; Kaiser Family Foundation 2006, 2008b.

Table 3-2. The United States Department of Health and Human Services: eleven agencies.

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Administration for Children and Families (ACF)  
Administration on Aging (AoA)  
Agency for Healthcare Research and Quality (AHRQ)  
Agency for Toxic Substances and Disease Registry (ATSDR)  
Centers for Disease Control and Prevention (CDC)  
Centers for Medicare and Medicaid (CMS)  
Food and Drug Administration (FDA)  
Health Resources and Services Administration (HRSA)  
Indian Health Services (IHS)  
National Institutes of Health (NIH)  
Substance Abuse and Mental Health Services Administration (SAMHSA)

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Sources: HHS, 2008a, About HHS. Electronic document,  
<http://www.hhs.gov/about/index.html>, accessed March 2008.

Table 3-3. Road to universal health care, 1912 to 1965.

Year	Action
1912	Presidential candidate Theodore Roosevelt campaigned for health insurance for industry
1916	AMA social insurance committee recommended compulsory state health insurance
1920	AMA opposed governmental health insurance The Committee on the Costs of Medical Care began a five year research project on the U.S.
1927	health care system
1932	The American Federation of Labor (AFL) endorsed health insurance The Committee on the Costs of Medical Care recommended group payment for health
1933	insurance through private or government or a combination of the two methods The Committee on Economic Security (appointed by President Franklin Roosevelt) reported
1935	to Congress recommending federal health insurance for the elderly
1935	Social Security Act passes with no provision for health insurance for the elderly A bill for national health insurance was submitted to Congress by Senator Robert Wagner
1939	(D-NY) President Franklin Roosevelt called for universal health insurance in his State of the Union
1943	address President Roosevelt called the right for adequate medical care in his State of the Union
1944	address
1945	President Roosevelt called for good medical care in his State of the Union address
1946-	Wagner-Murray-Dingle bill for universal health insurance submitted to Congress in 1946 and
1947	reintroduced in 1947
1945	President Harry Truman sent a message to Congress calling for universal health insurance A revised Wagner-Murray-Dingle bill for universal health insurance was introduced to
1945	Congress
1948	AMA hired a public relations firm to defeat Congressional national health insurance plans President Harry Truman sent a second message to Congress calling for universal health
1949	insurance bill introduced to Congress advocating health insurance coverage for Social Security
1952	recipients Eisenhower administration supported a bill for government subsidy of insurance premiums
1954	for low income individuals the Forand bill was introduced to Congress (with the support of the AFL-CIO) to provide
1957	health insurance for Social Security recipients
1957	AMA delegates moved against the Forand bill the Kennedy-Anderson bill was introduced to Congress advocating wider benefits than the
1960	Forand bill
1961	King-Anderson bill presented to Congress (early version of Medicare) AMA formed the American Medical Political Action Committee to oppose health care
1961	legislation in 1961
1962	President Kennedy gave a televised speech support health insurance for the elderly in 1962
1963	President Kennedy sent a message to Congress regarding the health of the elderly
1963	the King-Anderson bill was reintroduced to Congress the House Ways and Means Committee was holding hearings on the King-Anderson bill the
1963	day President Kennedy was assassinated
1964	President Lyndon Johnson sent a message to Congress advocating Medicare
1965	the Mills bill was substituted for the King-Anderson bill
1965	Medicare and Medicaid passed as amendments to the Social Security Act

Source: Weeks and Berman 1985:xvii-xxviii.

## Notes

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<sup>1</sup> Only the Marshall Islands spent more on health care as a percentage of its GDP (15.4%). Comparing just the industrialized nations, Switzerland was second to the United States in GDP health expenditures (11.4%), followed by France (11.2%) and Germany (10.7%). Canada and the United Kingdom spent far less, 9.7% and 8.2% respectively (WHO 2008).

<sup>2</sup> The study was funded by eight foundations: the Carnegie Corporation, the Josiah Macy, Jr., Foundation, the Milbank Memorial Fund, the New York Foundation, the Rockefeller Foundation, the Julius Rosenwald Foundation, the Russell Sage Foundation, and the Twentieth Century Fund. The Social Science Research Council and the Vermont Commission on Country Life each provided a grant for specific study (Weeks and Berman 1985:271).

<sup>3</sup> The final report was a summary and interpretation of the studies with five major recommendations entitled “Medical Care for the American People, the Final Report of the Committee on the Costs of Medical Care” (Weeks and Berman 1985:18).

<sup>4</sup> The Deficit Reduction Act of 2005 citizenship rule affects an estimated three million U.S. born citizens who have neither a birth certificate nor a passport as well as aliens (see Rosenbaum 2007).

<sup>5</sup> Elders applying for long-term care are subject to a financial review of when and how much of their assets were transferred (e.g., to their children). Previously, the retrospective review was for three years; now it is five years. The goal behind the review is to screen out elders who have the financial means to pay for long-term care.

<sup>6</sup> The budget for ORHP’s Rural Health Care Services Outreach Grants fell from \$58 million in 2003 to \$38.88 million in 2007 to zero in 2008 (HHS 2007i).

<sup>7</sup> These health centers were consolidated in 1996 with the passage of the Health Centers Consolidation Act of 1996, Public Law 104-299.

## CHAPTER 4 BEBÉ SANO

### **Introduction**

Bebé Sano is a maternal child program expressly designed for Hispanic migrant farmworkers and their families. The program was administered by Rural Community Health Services, Inc. (Rural Medical Services), a not for profit organization that administered three community health centers in Cocke County, Tennessee.<sup>1</sup> Rural Community Health Services, Inc., henceforth, will be referred to as Rural Medical Services. The program was located at the Parrottsville Community Health Center. The program served a five county catchment area in eastern Tennessee, an area that included Cocke, Greene, Hamblen, Jefferson, and Sevier Counties. All of the five counties are designated as Appalachian counties (Appalachian Regional Commission 2007). Three of the five counties border North Carolina.

Rural Medical Services is headquartered in Cocke County, located 45 miles from Knoxville. The community health center utilized for the program was located in the third oldest town in Tennessee, Parrottsville. Parrottsville had a population of 121 in 1990 (Census Bureau 1993b). In 1992, the catchment area encompassed 2,081 square miles (Census Bureau 2000), with 6,252 farms, and 136,964 acres of harvested land (USDA 1999a:265-273). Much of the catchment area was rural with small communities and towns scattered throughout the region. Portions of the area were in the hills of Appalachia. The main office of Rural Medical Services was located Newport, the county seat of Cocke County. As we explored the town by car, the town appeared quite vigorous and prosperous. Rural Medical Services' Chief Operating Officer (CEO) assured us Newport was a healthy, prosperous town, but there were deep pockets of poverty within the county (Figure 4-1).

The organization's CEO possessed essential insight into the culture of the region; he was "born and raised" in eastern Tennessee with an understanding of the mountain culture. As an historical note, Moonshine was the main economy of Cocke County in the days of prohibition, an economy that lingered for a time, according to the CEO. In his words,

The county has quite a reputation. . . . It has quite a notorious reputation. It used to be a really, really wide open place, a lot of Moonshine. We used to have this guy, a gentleman on the board of directors, and his Dad was a Moonshiner. And his [son] says 'my Dad never took a drink in his life.'

The administrator continues in almost a whisper,

He made some of the best Moonshine around. But, it was an economic situation. . . . They would get arrested, they would go to jail, serve some time, and come out and make moonshine because they can make money off it—at least while they were still finding Moonshine operations. There's no money in it any more. Now, Cocke County has the dubious reputation of growing some of the finest marijuana in the southeast. . . . We have all this federal land around us, and the thing is you don't want to grow on your own land because they'll confiscate the land, so they'll go up to . . . we have the Smokey Mountain National Park; we also have the Cherokee National Forest, which is [nearby]—so there's places you don't want to go hiking. And during the summer, it seems like Viet Nam because there are so many helicopters in the air trying to spot [marijuana patches]. And two or three times a summer, we'll have a big burning out here, just up from where ya'll's hotel is a state park. . . .

The Department of Labor (DOL) does not give figures on the underground economy, but never the less, moonshine and marijuana was part of this region's economy.

Officially, the rurality of the catchment area is confirmed (Table 4-1). The U.S. Department of Agriculture's (USDA) 1990 classification of counties listed four of the five counties in the catchment area as rural with manufacturing dependent economies (USDA 1994b). Sevier County was classified as a metropolitan county with a service dependent economy, even though 63.2% of Sevier's population resided in rural areas (USDA 1994b). Cocke County was the only county in the catchment area classified as a persistent poverty county, although poverty was not confined to Cocke County (Table 4-3).

Manufacturing related employment dominated in most of the catchment area counties in the 1990s, yet agriculture remained viable in the region. More specifically, tobacco and tomatoes—crops which are hand harvested—were significant cash crops for the catchment area. Tennessee, in 1992, was ranked number three in the nation for tobacco production, behind only North Carolina and Kentucky (USDA 1999b:73). The intensity of tobacco and tomato farming in the catchment area was astounding.

Collectively the five counties harvested over 11,000 tons of tobacco in 1992 (U.S. Census Bureau 1994a:478-479). There were a total of 4,374 farms harvesting 12,214 acres of tobacco. Greene County had the highest number of tobacco farms (2, 357) and Cocke County had the second highest (655) each harvesting 6,288 and 1,469 acres respectively (U.S. Census Bureau 1994a:478-479). Nationally, Greene County was ranked number 32 out of all counties (U.S. Census Bureau 1994b:73). At the state level, Greene county was ranked number one in the state for tobacco production, while Cocke County ranked tenth in 1992 (Tennessee Department of Agriculture ND: 35, 50).

Cocke County had a total of seven farms harvesting 259 acres of tomatoes, in 1992, insignificant compared to the tobacco farms. However, comparing tobacco production to tomato production is misleading. For the same year, Tennessee was ranked eighth in the nation for tomato production and Cocke County was ranked 102nd in U.S. county rankings. By 1997, Cocke County harvested 556 acres of tomatoes and was ranked 57th among the top 100 counties in the nation (USDA 1999b:95).<sup>2</sup>

### **Sociodemographic and Socioeconomic Indicators**

Bebé Sano program's target population was a transient migrant farmworker population, and, as such, there was no quantifiable data for migrant farmworkers in the catchment area. E. Alan Dever's (1991) study of migrant farmworker's health is often cited in discussing this elusive

population's health status. For his study, Dever used Willacy County, Texas as one of his comparison counties. Willacy County, in 1990, was a persistent poverty county, 85% Hispanic—81% of those born in the United States—and nearly 40% of the population was composed of farmworkers. The county was predominately Mexican, accounting for 81.4% of the population (Dever 1991:3; U.S. Census Bureau 1993d:57, 330, 853). As a means of comparison for this case study catchment area and the status of farmworkers in eastern Tennessee, data on persons of Hispanic origin in Willacy County, Texas are reported with the data from Tennessee and used as a migrant farmworker base line for comparison of the social determinates of health.

#### **Selected Catchment Area Sociodemographic Indicators, 1990**

In 1990, the aggregate population of these five counties was 219,533—overwhelmingly white (97.1%), of European descent, and the majority (69.8 %) lived in rural areas.<sup>3</sup> In contrast, the farm population, a sub-population within the rural portions as described by the U.S. Census Bureau 1990 Decennial Census, was less than 10,000—4.4% of the population. Blacks accounted for 2.4% of the catchment area population, while persons of Hispanic origin numbered fewer than one percent (0.4%) of the population (U.S. Census Bureau 1993b).<sup>4</sup> Of the five counties, Cocke had the smallest population, with three-quarters of the population residing in rural areas (Table 4-1).<sup>5</sup>

As noted in Table 4-1, Hispanics were but a small portion of the population in the catchment area counties. Hamblen County supported approximately 134 persons of Hispanic origin, the largest proportion (0.7%) of Hispanics in the catchment area. In Cocke County, there were 144 Hispanics (0.5%) counted in the 1990 Census. It is important to note that the 1990 U.S. Census category “persons of Hispanic origin” is independent of race and can include first, second, or even third generation of persons born in the United States who are of Hispanic origin.

However, this classification does not tell us much about migrant farmworkers who may have traveled through the catchment area working the agricultural cycle or those who have permanently settled in the area. Although, there was a clear presence of Mexicans in all five counties (Table 4-2) (U.S. Census Bureau 1993b:16-19, 22).

Mexicans accounted for only a small portion of the Hispanics documented by the U.S. Census Bureau in the catchment area (U.S. Census Bureau 1993b:16-19, 22; U.S. Census Bureau 1993d:57). Within the catchment area, Sevier County had the largest proportion of Mexicans (47.4%). Greene County had the smallest percentage of Mexicans (16.3%) within the Hispanic population. Hamblen County was oft cited by staff at the clinic in Parrottsville as the county where migrant farmworkers settled-out to work in the poultry processing plants; Mexicans accounted for 41% of the Hispanic population in Hamblen County.

### **Selected Catchment Area Socioeconomic Indicators, 1990**

The catchment area, in general, fared less favorably than Tennessee or the United States. For the counties in the catchment area, poverty levels were higher, per capita incomes were lower, and the unemployment rates were higher than the national level.<sup>6</sup> Compared to Tennessee, three counties (Hamblen, Jefferson, and Sevier) had lower poverty rates, but fared worse in all other categories. As might be expected, Cocke County had the highest poverty rate, the lowest per capita income, and the highest unemployment rate of the five counties. In comparison, Hispanics in Willacy County, Texas fared far worse all on measures than Cocke County—the most economically depressed county in the catchment area (Table 4-3).

#### **Poverty rate**

Poverty rates in the catchment area were higher than the national rate (13.1%). And while all five counties in the catchment area are designated as Appalachian counties, only two of the counties—Cocke and Greene—had higher poverty rates than the state rate (15.7%). Sevier

County had the lowest poverty rate (13.2%), considerably lower than the state level, and nearly equal to the national rate. Cocke County had the highest poverty rate (25.3%) in the catchment area, as one may expect given its persistent poverty status. Cocke County was ranked the 9th poorest county in the state (406th in the nation) (U.S. Census Bureau 2007e). In comparison to Cocke County, Willacy County, Texas, had a poverty rate nearly double that in Tennessee, 50.4%, and ranked the 28th poorest county in the United States, and number two in Texas (U.S. Census Bureau 1992a).

### **Per capita income**

The per capita income for the catchment area was below the U.S. (\$14,420) and state (\$12,250) levels. Within the catchment area, Cocke County had the lowest (\$8,574) per capita income. The other four counties demonstrated a relatively small range from \$11,127 (Hamblen County) to \$10,161 (Greene County), and were well below the state and national levels. The per capita income for Hispanics (\$4,363) in Willacy County was half the amount of Cocke County.

### **Unemployment rate**

The U.S. unemployment rate (4.1%) was substantially lower than Tennessee's (6.4%) (Table 4-3). Within the catchment area only one county had a rate lower than the state level, Hamblen County (6.2%), and yet was 51.2% higher than the national unemployment rate. Cocke County suffered the highest unemployment rate (10.8%) in the catchment area, more than double the national rate. The Hispanic unemployment rate in Willacy County, Texas was 17.3%. In comparison to Cocke County, Willacy County's unemployment rate was substantially higher (60.2%) than Cocke County's.

### **Educational attainment**

Educational attainment, as measured by the percentage of the population 25 years and older with a high school diploma or a graduate equivalency diploma (GED), was lower in the

catchment area compared to U.S. and Tennessee levels (Table 4-3). Approximately 59% of the aggregate catchment area population held a high school diploma in 1990—considerably less than the national rate (75.2%). Following the general patterns for other social indicators, Cocke County had the lowest educational attainment rate (50.4%) in the catchment area, and Sevier County had the highest (63.0%). Comparatively, the educational attainment rate for Hispanics in Willacy County was dramatically lower (32.7%) than any of the counties in the Bebé catchment area.

### **Selected Health Outcomes, 1992-1994**

#### **Mortality Rates**

Mortality rates (three year average for the years 1992-1994) for the three leading causes of death (heart disease, cancer, cerebrovascular disease) and suicide were generally higher for the Bebé catchment area counties than the U.S. rates. Willacy County rates were considerably lower (Table 4-4).

- **All Causes:** only Sevier and Willacy had lower mortality rates;
- **Heart:** all counties had higher rates except for Willacy;
- **Cancer:** Hamblen, Jefferson, Sevier, and Willacy had lower rates;
- **Cerebrovascular:** Sevier and Willacy had a lower rates, and Hamblen had a rate over two and a half times that of the U.S. rate; and
- **Suicide:** Hamblen, Jefferson, and Willacy had lower rates.

In comparison to Tennessee's mortality rates, the catchment area county rates were generally higher with a couple of notable exceptions (Table 4-4):

- **All Causes:** Sevier and Jefferson Counties had lower rates than the Tennessee;
- **Heart:** only Jefferson County had a lower rate;

- **Cancer:** all counties except Cocke County had a lower rate;
- **Cerebrovascular:** Greene, Jefferson, and Sevier Counties had lower rates, but Hamblen had a rate twice that of Tennessee; and
- **Suicide:** Hamblen and Jefferson had lower rates than the state.

**Mortality rates within the Bebé Sano catchment area.** Cocke County generally had higher mortality rates when compared to the other five counties.

- **All Causes:** Cocke County had the highest rate;
- **Heart:** only Greene County had a higher rate;
- **Cancer:** Cocke County had the highest rate;
- **Stroke:** only Hamblen had a higher rate; and
- **Suicide:** Greene and Sevier had higher rates.

Willacy County's health indicators, with the exception of suicide, were the lowest of all counties.

#### **Infant Mortality Rates 1992-1994**

The infant mortality rates for the Bebé Sano Catchment counties, with the exception of one, were substantially lower than the national and state rates (Figure 4-4), reflecting a predominant white population.<sup>7</sup> An analysis of the infant mortality rates in the catchment area is problematic due to the low numbers of deaths during the three year time period from 1992 to 1994 in the five counties except Hamblen. Hamblen County had 18 white infant deaths and two black infant deaths. In the other four counties the infant deaths ranged from seven in Cocke County to 12 in Greene County.

Willacy County demonstrated mortality rates considerably lower than the United States, Tennessee, and the catchment area. Willacy County's low mortality rates for the three leading causes of death appear to be a conundrum given the extraordinary high poverty and extremely low educational attainment in the county in 1990. One plausible explanation is that Mexicans, who comprised 81.4% of the population, returned to familial ties in Mexico to die (U.S. Census

Bureau 1993d:57). The health of migrant farmworkers is complex and difficult to document. The next section provides a brief overview of their health.

### **Migrant Farmworker Profile**

Luis Sullivan, MD, former Secretary of the United States Department of Health and Human Services from 1989 to 1993, described the challenges of migrant farmworkers as “varied and extensive” (Sullivan 1992). Among the critical issues faced by migrant farmworkers, according to Sullivan, are the following: (1) poverty, (2) low education, (3) low English language proficiency, (4) lack of United States cultural knowledge, (5) substandard housing, (6) inadequate sources of running water and plumbing, (7) working in the most hazardous occupation—which includes exposure to extreme weather conditions and pesticides, (8) living in rural isolation, (9) lack of health care, (10) insufficient child care, (11) poor nutrition, (12) high infant mortality rates, and (13) early deaths. Dr. Sullivan (1992) perceives migrant farmworkers and their families as a vulnerable population in need of an array of services to meet their needs.

The number of migrant farmworkers working in the United States is considerable. The estimates range from about 1.5 million to nearly five million (Ryder and Shepherd 2006:3; see also, DOL 1994:31:2). Jack Egan, then Acting Director of the Migrant Health Program, Health Resources and Services Administration, estimated the number of migrant workers to be between three to five million (Migration World 1992). Thousands flow through Tennessee each year, the majority arrive to harvest tomatoes, strawberries, and tobacco. The vast majority are from Mexico traveling from home bases in Texas, Florida, and Mexico.<sup>8</sup>

From field research conducted in 1995 at three Migrant Health Centers in eastern Tennessee, it is clear that the migrant population at work in Tennessee is not homogeneous even though the vast majority of the farmworkers are from Mexico. One migrant program director remarked that there are many classes within the migrant population, with varying levels of

education, familiarity with U.S. culture, and understanding of medical issues. It is not uncommon, he told, us that new migrants arriving to eastern Tennessee to harvest strawberries have never shopped in U.S. retail stores. As an example, he explained how every summer he has to teach at least one migrant wife how to shop in the local grocery store, having never shopped in a *supermercado* (grocery store) in Mexico. The *supermercado* is a phenomenon found only in urban Mexico. In the rural regions of Mexico grocery stores, called *tiendas*, are small family operated businesses and an integral part of the rural community. The above example suggests that new migrants from rural regions of Mexico enter the migratory stream each year, with little cultural knowledge or “cultural capital” (see, Massey 2000; Massey, Goldring, and Durand 1994; Fussell 2004, for an in-depth discussion of cultural capital).

Sociologist Elizabeth Fussell (2004:944-945), in a study using data from the Mexican Migration Project, found that persons living in the rural interior of Mexico are four times more likely to migrant to the U.S. than those living in urban areas, mostly for agricultural work. The inhabitants of the rural interior have an average of 4.4 years of schooling, much lower than their urban counterparts.<sup>9</sup> The more years of education, the less likely one is to attempt an undocumented U.S. migration (2004:949). In addition, Fussell found that in rural interior communities the likelihood that an individual would make a first trip to the U.S. as a migrant worker increases by 86% if a parent has migration experience and 253% if a sibling has migrant experience.<sup>10</sup>

While shopping for food in the local grocery store is viewed as a natural act, it is clearly not basic cultural knowledge for those entering the United States from the rural regions of Mexico. Kimberly Grimes describes new migrants to the United States as uprooted “from their conventional ways of understanding the world,” as people who “enter a terrain filled with new

people, new images, new life-ways, and new experiences” (1998:66). Mexico is a country with many indigenous ethnicities, some of whom remain isolated from urban Mexico. In the state of Oaxaca, for example, there are 14 indigenous languages spoken with over a million indigenous language speakers (Stephens 2005:133).<sup>11</sup> In California, it is estimated that indigenous farmworkers make up 20% of the state’s farmworkers (Aguirre International 2005:12). Interviews with migrant personnel at the three Tennessee Migrant Health Centers (Morfit unpublished monograph 1995), the majority of healthcare practitioners reported encounters with farmworkers who spoke neither English nor Spanish, but rather, an indigenous language.

### **Sociodemographic Characteristics**

The U.S. Department of Labor (DOL) periodically conducts a demographic and employment survey of migrant and seasonal farmworkers working in the United States.<sup>12</sup> The survey, referred to as National Agricultural Workers Survey (NAWS), provides a national profile of the farmworker population. The 1990 NAWS report indicates that the majority of the nation’s farmworkers are young, married, from Mexico, with low educational attainment (DOL1991). They are among the poorest of the poor, few have health insurance, and for those who qualify for Medicaid services, few use this public assistance program (see also, Arrieta, Walker, and Mason 1998; DOL 2005; Guarnaccia et al. 1992; Mines, Gabbard, and Steirman 1997). There are several caveats to the survey: (1) the survey represents only those farmworkers actively engaged in agricultural work, thus family members who reside with the interviewee or those temporarily not employed are not included in the survey data; (2) the survey includes seasonal agricultural workers who do not migrant for work for example, in the 1990 NAWS report only 42% of those interviewed migrated for work, somewhat skewing the data when one is trying to ascertain the national characteristics of the migrant farmworker population (DOL 1991:64; see also, DOL 1994:3). In addition, Tennessee is not represented in the NAWS annual surveys.

Thus said, the NAWS data does not provide discreet data specific to Tennessee migrant farmworkers. In essence, sociodemographic and employment patterns for Tennessee migrant farmworkers are unavailable. Relatively scant migrant farmworker research has been conducted in Tennessee.<sup>13</sup> And unlike the home-base states of California, Texas, and Florida where the growing season is longer, the farmworkers' stay in Tennessee is comparatively brief (peak season is July and August) and, they remain relatively invisible—working in isolated rural pockets, mostly in Eastern Tennessee.

### **Profile of Florida Migrant Farmworkers: A Comparative Population**

Martha Arrieta and colleagues' (1998) analysis of cumulative NAWS data (October 1989 to November 1995) for Florida agricultural workers is much more useful for the purposes of illustrating migrant farmworkers characteristics. Their findings often were reported in two subgroups—"migrant" versus "settled." For example, the majority, 68%, of 2,872 Florida farmworkers who provided data for the survey were migrant farmworkers; 32% of the farmworkers were "settled," or seasonal farmworkers. In comparison, only 47.4% of NAWS sample are migrant farmworkers (Arrieta, Walker, and Mason 1998:22).<sup>14</sup> Therefore, Arrieta, Walker and Mason's (1998) findings are more applicable to the Tennessee migrant farmworker population for a general profile. Their findings include:

- 86 % are of Hispanic origin (all farmworkers);
- average age is 29 years versus 34 years for settled farmworkers;
- 83% report Spanish as their primary language (all farmworkers);
- 37% report their residency outside of the U.S. (all farmworkers);
- 37% report their residency outside of the U.S. (all farmworkers);
- migrant farmworkers spend approximately 6.3 months in Florida versus 11.5 months settled workers;

- 73% of the migrant families live in poverty versus 54 % settled farmworkers;
- 32% claim Mexico as their permanent residence (all farmworkers);
- migrant farmworkers primarily work vegetable, fruit & nuts, and field crops;
- 86% are involved in harvest tasks versus 1% in supervisory tasks versus 50% and 2% respectively settled farmworkers;
- 85% did not have employer-provided health insurance versus 73% settled workers;
- only 13% accessed migrant clinics (all farmworkers); and
- 4% reported returning to their country for health care.

Arrieta and her colleagues (1998) provide a portrait of migrant farmworkers as a younger and poorer group than the settled farmworkers of Florida. They are more likely to be involved in harvesting crops than their counterparts. Few have employer-provided insurance and even fewer rely on migrant health clinics for their health care, even though there are many migrant health centers in Florida.

### **Migrant Farmworker Health Status**

At present there is no population-wide comparative health indicators e.g., morbidity and mortality rates, for migrant farmworkers (Galarneau 1992:30; Migrant Clinicians Network 1992). In fact, resources for farmworker healthcare are “severely hampered by the scarcity of data” (Migrant Clinicians Network 1992:6). National, state, and regional surveys and studies, however, indicate migrant farmworkers have a higher disease burden and vastly more complex health needs than the general U.S. population (Achata 1993; Arcury et al. 2005; Betchtel, Shepard, and Rogers 1995; Boltwood and Chapman 1998; Dever 1991; Early et al. 2006; Guarnaccia et al. 1992; Meister 1991; Migration World 1992; National Advisory Council on Migrant Health 1993; National Center for Farmworker Health 2001, 2004; Thompson et al. 2003).<sup>15</sup> Public health studies also suggest migrant farmworkers and their families have low

access to health care facilities (Arrieta, Walker, and Mason 1998; Azevedo 2001; Dever 1991; National Advisory Council on Migrant Health 2000; Ponce and Black 2003.)<sup>16</sup>

E. Alan Dever's study (1991) is cited as a seminal work on migrant health issues (Galarneau 1992; Gwyther and Jenkins 1998; Larson 2001; Migrant Health Magazine 1992). Dever's research encompassed four migrant health centers for a total of 6,969 patient encounters in three states, Michigan, Indiana, and Texas. The home base counties for the study were in Texas: Cameron, Hidalgo, and Willacy. Only Willacy is categorized by USDA as a persistent poverty county. Cameron and Hidalgo were classified as urban counties, thus Willacy is an appropriate county for comparison in this study.<sup>17</sup>

Dever found that migrant farmworkers' clinic visits were dominated by infectious diseases and chronic health issues (see, Table 4-6). Diabetes was the most common diagnosis documented in the migrant health centers (ranked number one), followed by "health supervision of infant or child." The third most common diagnosis was otitis media, with normal pregnancy ranking fourth. The fifth ranked diagnosis was acute upper respiratory infection. Twelve of the top twenty causes for clinic visits by migrant farmworkers involved infectious diseases, indicating that the migrant population was "victimized by an infectious disease cycle" (1991:6). Dever stresses that migrant farmworkers access migrant clinics for infectious, nutritional, occupational health concerns, "which not do even rank in the top twenty conditions for the general U.S. population" (1991:13).

Joel Meister<sup>18</sup> (1991) stresses the multiple health hazards precipitated by working in the fields, including hazards to mothers, children and fetuses (1991:508). For example, pesticide and chemical exposure due to working in the fields, living near the fields, or contact exposure from contaminated clothing from field workers can be extremely dangerous to pregnant women

and their unborn children. Thompson and colleagues (2003) conducted a group randomized trial (N=571) of mostly Hispanic farmworkers in Washington state and found children residing in agricultural worker households were positively associated ( $P < 0.0001$ ) with pesticide exposure. Similarly, Arcury et al (2005) in a limited study of Hispanic migrant farmworker households in North Carolina and Virginia (N=9) found all participants had measurable pesticide metabolites in their urine—all but one well above normal (2005:44).

Some pesticides and chemicals may cross through the “placenta barrier and have mutagenic, teratogenic, carcinogenic, or neurotoxic effects” (Meister 1991:508).<sup>19</sup> In addition, physiological changes brought on by pregnancy such as increased lung capacity enhances the probability of pesticide inhalation. Pesticide induced anemia is also a risk for child bearing women, diminishing their chances for normal pregnancies. Furthermore, pesticides and chemicals can be passed on to newborns through their mother’s breast milk (Meister 1991).

According to Meister (1991) other risks associated with agricultural work for women and their children include accident and injuries, urinary tract infections, oral-fecal contaminations, diarrhea, malnutrition, and viral infections. Children are particularly vulnerable to pesticide poisoning due to their higher metabolism, low body weight, and potentially long-term exposures. Children working in the fields are far more at risk for pesticide and chemical exposures (Meister 1991: 508).

A number of public health studies conducted within geographical proximity to the eastern Tennessee program site, echo Dever and Meister’s findings (Achata 1993 [Tennessee], Bechtel, Shepard, Rogers 1995 [Georgia]; Boltwood and Chapman 1998 [Virginia]; and Early et al 2006 [North Carolina]). In the mountains of northwest North Carolina and southern Virginia, Early and her colleagues (2006) conducted an intervention project (*La Familia*) to reduce pesticide

exposure to farmworkers and their families (N=41 families). They found that housing was inadequate, with the majority of families living in trailers and under crowded conditions. Nearly half of the homes were adjacent to the fields, increasing their potential exposure to pesticides; furthermore, nearly all of the homes lacked air conditioning, further increasing their exposure to pesticides (Early et al 2006:177-178).

Another variable for pesticide exposure is access to laundry facilities. The Environmental Protection Agency (EPA) recommends that all agricultural workers bathe as soon as they arrive home, changing into clean clothes, and to keep work clothes separate from the family laundry (EPA 1993:12-13). Early and her colleagues found that nearly half of the families relied on public laundromats (2006:179). In theory, the EPA's recommendations are sound; however, in the daily life of migrant farmworkers traveling through Tennessee, they are difficult, if not impossible to follow. One informant (1995) described the housing situation in rural Tennessee as deplorable. Houses and trailers that had been condemned suddenly were for rent when the migrant season began. In some cases, running water meant a garden hose passed through a trailer window.<sup>20</sup> Many of the migrant farmworkers directly flowed from the Mexican countryside, with little knowledge of EPA recommendations.<sup>21</sup>

### **Program History**

In the early 1980s, Public Health officers stationed at HRSA's Migrant Health Branch Office in Atlanta (one of ten HRSA Regional Field Offices at that time) had been monitoring the patterns of migrant farmworkers and their families' use of community health centers (CHC).<sup>22</sup> The regional office detected a dramatic increase in migrant women of child bearing age accessing CHCs in Tennessee (personal Communication with Dr. Galo Tores, U.S. Public Health Commissioned Corps Officer, Director Migrant Health Branch, Atlanta Regional Office 1995). As a result, the CEO for Rural Medical Services was approached by a Migrant Health Branch

official from the Atlanta Field Office to develop a maternal child health care program in a five county catchment area. Rural Medical Services operated a system of three community health centers in Coker County that served the rural and underserved populations. The county bordered three of the four counties, and close to the fourth, all of which had significant populations of migrant farmworkers during the harvesting season. Rural Medical Services' three CHCs were, in part, financed by HRSA's Bureau of Primary Health Care, thus given the data that migrant women of childbearing age were in the area, Rural Medical Services' CHCs fortuitously possessed the infrastructure necessary to implement a project for migrant women and their babies.

Rural Medical Services' contact person for the HRSA field office was the Rural Medical Services' CEO. The CEO had the dilemma of asking Rural Medical Services' Board to approve a project that had no funding or to decline the request of the Public Health Service (HRSA), a federal agency that proved funds for all of the organization's three community health centers.<sup>23</sup> The CEO took it to the Board for approval. Some opposed the project, but it was ultimately approved.

As suggested by the Migrant Health Branch official, Rural Medical Services designed and implemented the program in 1985 to accommodate migrant women of childbearing age. Migrant farmworkers—mostly Mexicans—some accompanied by their families, had been streaming through the area to work in the tomato and tobacco fields in the vicinity of Coker County long before the program was conceived. Rural Medical Services' Parrottsville community health center was the closest of the three to the agricultural fields, making it the logical choice to host the migrant program.

The program was implemented within the existing perinatal services available at the Parrottsville community health center (Figure 4-2). A staff specific to the program was recruited. Several of the staff were bilingual, helping to facilitate patient encounters. By design, the program provided clinic hours beyond the traditional operating hours of 8:30 a.m. to 4:00 p.m., Monday through Friday, to accommodate the work cycle of the farmworkers. Saturday hours, plus one evening clinic a week, were set aside for the migrant farmworkers.

### **Program Description**

In preface to the description of the *Bebé Sano* program, it is important to note the perinatal care crisis that existed in Cocke, County. Rural Medical Services, in 1994, was experiencing an increase in patient load and fewer resources for a variety of reasons, which will become more apparent below, and found they were delivering more babies. According to the organization's CEO, there was one private obstetrician/gynecologist (OB/GYN) and seven family practitioners in Cocke County. The solo obstetrician did not take high-risk pregnancies, therefore all high-risk pregnancies were referred to Knoxville. Adapting to the situation, all of the family practitioners, including those employed by Rural Medical Services, delivered babies and performed cesareans when necessary. The CEO estimated "we are about the second busiest group in town, and we'll do over 130-150 deliveries each year. Live births in the county are between 350 and 400."<sup>24</sup>

The *Bebé Sano* program, as discussed above, was designed to provide migrant women and their children access to maternal/child health care—more specifically, to improve access to health care for pregnant migrant women within the catchment area.<sup>25</sup> Most of the migrant women did not possess "immigration papers," transportation, basic health knowledge, and did not speak English, all of which severely limited their access to health care, according to the Program Coordinator.

The program coordinator estimated in 1995 the program would serve, “at least 50 pregnant migrant women and 50 to 100 women of childbearing age.” The majority, if not all, of the migrant farmworkers seen at the community health center were from Mexico, and many women who had given birth in Mexico reported they gave birth at home.<sup>26</sup> Unfortunately, there was no estimate of the number of women in the catchment area who chose to deliver their babies at home while in Tennessee.

Services available to migrant women through the *Bebé Sano* program included perinatal clinical exams, laboratory testing, ultrasound, delivery, health education, family planning, well baby checkups at two and six weeks, the provision of contraceptives, referrals to specialists, and referrals to obstetricians for women moving before delivery.<sup>27</sup> The program coordinator estimated that at least 25 women would leave the area before their babies were born. The program also provided women leaving the area with a complete set of their medical records.

Health Education was an essential co-objective of the program. As one staff member pointed out, for some, coming to their community health center was the first time they ever seen a doctor, and many women did not understand the importance of prenatal care. The program’s health education, by design, was delivered through various modalities and venues to accomplish this objective. All health education materials were provided and/or delivered in Spanish. The staff provided a packet of health education materials to all first time obstetrical (OB) patients, which included information on the process of pregnancy and birth, breast feeding, immunizations, and other related topics. To educate illiterate mothers a number of modalities were used: videos, one-on-one sessions, and group sessions (large and small). Health education took place in the community health center, through outreach in the migrant camps and “housing clusters,” in the fields, and informally when the women were transported to and from the clinic.

The outreach worker/health educator in 1994 stated she had tried to go to the fields to distribute information on the community health center and their services and to deliver health education information, but it was very hard because “the workers are hard working” people and do not want to take the time to leave the fields. She said it was impossible to get a small group together at field sites for health education sessions. In another venue, health education material was distributed at two health fairs targeting the migrant population. Health education and answers to health-related questions were provided by the driver during the long trip to the CHC and back home to the migrant housing near the fields. This housing was often poorly constructed and maintained, providing ample suggestions for hygiene discussion topics.

The migrant program, in order to provide optimal care to their clients, developed linkages with the Cocke County Public Health Department, the local hospital in Newport (Cocke County), the University of Tennessee, local Catholic churches, the Tennessee Opportunity Program (TOP), and various social service agencies to refer migrants to additional services unavailable at the community health center.<sup>28</sup> Examples include, every mother or prospective mother was enrolled in the WIC program; eligible uninsured mothers were transported to the TennCare office to enroll in the state’s Medicaid program, aided by program provided translation services; and ultrasounds conducted by the Baptist hospital in Newport.<sup>29</sup> Several crucial components were designed into the program to improve access to health care, such as: outreach, transportation, and translation services.

## **Outreach**

The active outreach effort was a critical component of the program, designed to locate and identify migrants in need of the program’s services. The *Bebé Sano* outreach staff went to where the migrants lived, worked, and socialized. Migrants are reluctant to access health care except in cases of dire need, so the program was designed to incorporate an outreach worker—one who

was bilingual and sensitive to migrant needs. In the early stages of the program, the program coordinator doubled as the outreach worker. By 1994, the program had an outreach worker, who was also the health educator. A new outreach worker was in the process of being hired at the time of the site visit, providing the health educator more time to concentrate on the task of teaching. The outreach worker visited migrant labor camps, housing clusters, places where migrants frequented for example, in public laundry facilities and grocery stores.<sup>30</sup> The outreach worker was also tasked with placing flyers in areas where migrants would be most likely to see them, “in at least 10 public and gathering places frequented by migrants” as stated by the program coordinator.

The outreach worker visited the migrant camps and the housing clusters a minimum of three times during the season, May through October, in an attempt to locate and identify pregnant women. Once a pregnant migrant was located, the outreach worker spoke with her about the importance of prenatal care, and encouraged her to come to the community health center for care. The outreach worker also provided migrant women information about clinic services, including directions and a map. Integral to the outreach worker was the bilingual driver. The bilingual driver usually accompanied the outreach worker in her endeavors to locate pregnant migrant women in need of the *Bebé Sano*'s services.

### **Transportation**

The *Bebé Sano* staff soon discovered that many of the migrant clients lacked transportation to reach the community health center. Most of the stay-at-home women required some form of transportation to access the center during the weekday hours (8:30 am to 4 pm) because their husbands were working in the fields from sun up to sun down (Figure 4-3). However, husbands would accompany their wives to appointments on Saturdays and for the evening clinics.

There was a gentleman in the community who had taken a personal interest in the migrant farmworkers. This gentleman had taught himself Spanish, and slowly got to know some of the migrants. He eventually was hired to transport migrant farmworkers' family members from their homes to the community health center. His position as driver was also one of translator and interpreter. The driver routinely transported migrant women to the TennCare office to apply for Medicaid, translating and interpreting when necessary. We had the opportunity to follow the driver on one of his return trips ferrying a number of migrant women and their children to their homes. The children were mostly young, one as young as eight weeks old. The migrant troupe had left home very early in the morning and had been at the clinic the entire day (it was around five o'clock when the van left the community health center), so most had not eaten since they left home. The children were tired, thirsty, and many of the young ones were crying.<sup>31</sup> The driver's first stop was at a small store not far from the community health center—apparently a routine stop—so they could purchase drinks and small snacks or other items they needed, since opportunities to visit a store were limited for these home-bound women.

The trip to their homes wound us through miles of agricultural fields and dirt roads. All of the families lived alongside the fields, some in bare, concrete block structures with few windows for ventilation. The concrete structures were very small and it was not clear if they had running water and plumbing. The small enclave of stark, barren structures was set in relief between acres and acres of lush farmland and a golf course—contrasting opulent affluence and abject poverty.

### **Translation**

Probably the most significant component of the program is the ability to translate and interpret for the migrants. Most migrants spoke Spanish only—some spoke only their native indigenous languages—critically hampering their access to health care. When the program was designed, the goal was to have as many bilingual staff members as possible. At the inception of

the program only the program coordinator and two physicians spoke Spanish. Overtime, a bilingual health educator and driver joined the program. The majority of the program coordinator's time was absorbed by the necessity to translate and interpret for the nurse practitioners and the patients in the community health center.

I observed two clinical encounters where the program coordinator translated for the nurse practitioners.<sup>32</sup> The first patient was a young woman who was six weeks postpartum. Accompanying her were her newborn and young toddler, approximately eighteen months old. At this point of the exam, the program coordinator was called in to provide birth control (pills) instructions. I watched as the coordinator quickly paraphrased the instructions for the patient. The patient's expression never changed through the entire translation. Even when the coordinator asked if she had any questions, the young woman just stared at her, no smile, no frown, just an expressionless stare. She appeared polite, but never spoke a word. I looked at her face, stature, and dress. She appeared to be Maya. In my estimation, she did not speak Spanish, nor did she understand the instructions. I consequently learned in a later interview with the migrant medical director (1995), that there was a significant Maya population among the migrant farmworkers. He further added, "they usually have someone who speaks Spanish with them."

The second clinical observation was a 30 year old woman who came to the community health center specifically for birth control pills. The nurse practitioner had already examined the patient and was waiting for the program coordinator to explain the results of the exam to the woman. When the program coordinator and I walked into the room, the mother was sitting on the floor playing with her two children. The youngest child was not quite a year old, the mother had just stopped breast feeding him. The older child was barely two and appeared to be very active and healthy. The information the nurse practitioner wanted to relay the patient was brief:

she was eight weeks pregnant. Upon learning this, the look on the face of the mother was one of desperation.

## **Staff**

In 1994, there were five personnel who worked for the Bebé Sano program: the migrant program medical director, the program coordinator, the community outreach worker, the health educator, and a driver/translator; all of who spoke Spanish. Complementing the Bebé Sano personnel were Parrottsville's perinatal staff, which included: two physicians (fluent in Spanish), four family nurse practitioners, and one Licensed Practical Nurse (LPN ). Many of the staff were from the catchment area or Tennessee. They appeared to have a strong sense of community, are exceptionally committed to the program, and are proud of their work. The community health center building had been a part of the high school, long since gone. The clinic's LPN had attended high school in Parrottsville and joked that it felt like she never left high school.

A profile of the Bebé Sano core staff provides great insight into the program. The CEO is included in the below profiles, for he was the critical link that tied the program together from its inception to its implementation by Rural Medical Services. The staff profiles also include the medical director of Rural Medical Services because of his direct supervisory role and unique background knowledge.

### **Chief executive officer (CEO)**

The CEO of Rural Medical Services was the central point of contact between HRSA's regional office in Atlanta, which includes the Migrant Health Branch. He initially presented the project proposal to the Board. The proposed program in all probability would have perished well before it reached the planning stage if it had not been for the CEO's intervention.

The CEO held a B.S. in Health Education and a Masters of Public Health (MPH) from the University of Tennessee. After receiving his MPH, he worked in the health administration field

and subsequently with the U.S. Public Health Service in Mississippi and Philadelphia with the Choctaw. At the time of the site visit, the CEO had been with the organization for 13 years. He joined the organization as CEO three years after Rural Health Services began administering the three community health centers in 1979.

The CEO was “born and raised” in this region of Tennessee. He harbored a deep commitment to the catchment area, to eastern Tennessee, and the rural poor whom his organization served. He and his family reside outside of Cocke County, yet he had developed a bond, an allegiance to the county and to the migrant farmworkers. He proudly showed us poster size pictures he had taken of migrant farmworkers working in the tomato fields. They were very powerful pictures capturing the intensity of the labor. One depicted a farmworker picking tomatoes amidst towering, dense rows of tomato plants heavily overflowing with fruit, plants that overshadowed the farmworker.

The CEO possessed a keen sense of the larger picture of health care delivery. He was connected to state and national organizations and worked on issues that impacted the organization’s three community health centers. At the time he was the president of the Tennessee Primary Care Association, an association largely composed of affiliated community health center physicians and administrators; actively involved with Tennessee Medical Association; and had a longstanding relationship with HRSA and its many bureaus and programs. He possessed a strong voice in rural health care delivery, one which resonated throughout Tennessee.

### **Physicians**

Rural Health Services retained two full-time physicians. One was the medical and the other was the migrant program medical director. The medical director and the migrant program medical director had flexible schedules between the three community health centers with the

migrant program medical director primarily staffed the Parrottsville center during the migrant season.

Both physicians came to the organization with unique backgrounds. The medical director was born in South America to U.S. Presbyterian medical missionaries. The family traveled extensively throughout South America, living in various countries. When he was ready to attend college, he was sent to the United States. He came to the organization as a National Health Service Corps (NHSC) physician assigned to Rural Medical Services for a limited time. Rural Medical Services had had four or five NHSC physicians in the past, but none had chosen to stay after his or her NHSC commitment expired. The CEO referred to this national program (NHSC) as a “revolving door,” where doctors were assigned and usually left when their contract obligation had been met, leaving the patients with unreliable continuity of care. However, the medical director, due to a number of factors, remained with the organization.<sup>33</sup> He was the first NHSC doctor retained by Rural Medical Services, and, according to the CEO, that launched them “in a new era of stability . . . and then from that we recruited our [migrant program medical director].”<sup>34</sup>

The migrant program medical director was originally from New York. He spent ten years in Honduras as a medical missionary with his wife and three children. They had lived with the Mískitu in a remote region of Honduras.<sup>35</sup> When his children were of elementary age (third, fifth, and seventh grade), he and his wife decided it was time to bring them to the United States. He felt ten years was enough and it was time to come home. He still wanted to use his skills serving underserved populations as well as work with Hispanics. Rural Medical Services was a good fit, including a colleague with whom to work.

### **Migrant program coordinator**

The migrant program coordinator was relatively new to the Bebé Sano program having worked for Rural Medical Services for about eight months. She graduated in May 1993 from Maryville College just south of Knoxville, Tennessee. She held degrees in psychology and sociology with a minor in Spanish. She completed a practicum in the spring of 1993: she jointly worked with Rural Medical Services and a local Catholic church in Hamblen County providing assistance with outreach and translation for migrant farmworkers. This affiliation translated into a full-time position as Bebé Sano's program coordinator with Rural Health Services in November 1993.

Her duties as migrant program coordinator included: supervision of Bebé Sano personnel, program design, grant writing, statistics collection, translation and interpreting, as well as interfacing with the perinatal program coordinator to improve services to migrant women. While all of these functions were critical to the program, the migrant program coordinator explained that one of her top priorities was grant writing. She was tasked with obtaining funding resources to sustain the program. She had just completed a grant proposal for the March of Dimes, and she was pursuing other potential prospects. Unfortunately, much of her time was absorbed with translating for the nurses, an integral and critical task which was necessary for the perinatal staff.

### **Outreach worker and health educator**

The health educator held a B.S. in Sociology (1990) from Carson-Newman College (located in Jefferson City, Tennessee). The health educator doubled as the program's outreach worker, a position she was well qualified to perform. At the time of our visit in August 1994, a new outreach worker was in training and was to start the following week. She was expected to fill the position for the 1995 season. Both the outreach worker and the health educator were part-time positions, allowing the health educator to perform both positions.

The outreach and health educator had a lengthy history with the Bebé Sano program: she was employed by Rural Medical Services from 1985 to 1992. She was the original Bebé Sano program coordinator and outreach worker, and she designed and implemented the Bebé Sano program—according to the current program coordinator. She took a year off and returned to the program in 1994 as the program’s health educator. At that time, the program did not have an outreach worker, so she filled in for the 1994 season.

### **Translator-driver**

The community health center driver had worked with the organization for some time, first as a volunteer and then as an employee. The driver was 65 years old on the day of our visit, and we attended his birthday celebration at the Parrottsville clinic. It was a taco party. He was wearing a large Mexican sombrero and his usual overalls, depicting his fondness and appreciation of the transient Mexican community culture (Figure 4-4).

In order to understand the depth of commitment this gentleman had for the migrant farmworker community and the Bebé Sano program, it is necessary to know his “story.” The gentleman had had a heart attack and open heart surgery in 1979, which led him to semi-retirement. He later took a minimum wage job as a security guard, which he found boring. To help relieve the boredom, he began checking out books at the library. Eventually, he read everything in the library. The only materials he had not mastered were foreign language instruction materials. The library had materials for only one language: Spanish. So he decided to learn Spanish.<sup>36</sup>

The CEO described him as:

a story in himself. . . . he worked in a factory [as a security guard], and he started seeing the migrants coming through the community and would have interactions—observe them in grocery stores and things like that. And took it on himself to teach himself Spanish—he taught himself Spanish! He sees it as a ministry—to minister—but he’s not one of those, you know, not ministry in the strict religious sense of the word, but his calling and. . . . For

the longest time, he provided free transportation, free translation services to the migrant population. If they were having trouble getting their car fixed, or getting something done at DHS—signing up for WIC, or whatever. And he would ferry them back and forth to our clinic [Parrottsville]. So, finally, after we got hit over the head by a two-by-four, it dawned on us that we should put this guy on salary some way. But he says that [he] can only do so much, so we do it in travel. We pay him—reimburse him for travel. He is the neatest little guy that you'll ever want to meet. And here is a picture for you: he always wears one of these little jumpsuits, and he always has a diet Coke in his hand. . . . No, I don't know Spanish. I don't know anything about it, but he is really good. He's totally bilingual and . . . his boss, he calls her his little chief. And it's—he's just—he is quite a character, and just a super nice guy. At our big Christmas last year, I found out that he's a twin, so there are two of them running around!

In 1990, the driver had a second open heart surgery. But he bounced back and continued his "Calling." The migrant program coordinator, in 1992, called him to work in the clinic, and "he has worked every day since." The driver had a multitude of responsibilities in relation to the program. He transported migrant women and their children to appointments at the community health center, to the hospital for ultrasounds, to the TennCare office to enroll in Medicaid, and to other agencies when appropriate. He also provided translation and interpretation services whenever necessary. The driver informally taught English to his passengers as he transported them throughout the area.

Over time, he gained a rapport with the women and their children he transported. He confided that many of the women he transported would show up with bruises, even black eyes at times. He said they tried to discreetly cover their injuries, but he would hear the conversations between the women. The driver observed that the women would experience more severe beatings when a male family member would join the family unit, especially if it was the husband's father. He said it was a show of male masculinity, proving to his male relatives that he had control over his wife. With deep concern and sadness, he explained many of the migrant women were victims of domestic violence.

## **Funding Sources**

The Bebé Sano program had extremely limited resources. The CEO explained the program did not receive funding from the Migrant Health Program in the form of 329 funds (see below). Funding for the program was derived from limited sources: Medicaid, sliding scale fees, fee for service, and small grants. The shoestring operating budget for the 1995 season was less than \$9,000. This budget did not include clinical medical treatment, simply direct program expenses. All of the staff positions were calculated on part-time basis, with the exception of the driver-translator who was paid by the mile and not compensated for his translation/interpreting services. Two brief examples are: (1) the program coordinator was to be paid ten dollars per hour, ten hours per week for 26 weeks; (2) the health educator was to be paid ten dollars per hour, 5 hours per week for 26 weeks. The program did not charge the migrants for outreach, transportation, interpreting, or educational services. There was, however, a fee for medical services provided at the community health center.<sup>37</sup>

## **Medicaid payments**

Medicaid reimbursement was severely limited for two distinct reasons, (1) the new state Medicaid program (TennCare) and (2) immigration status. TennCare, which will be discussed in more detail below, had been in place for less than nine months, at the time of the site visit. Even at this early stage, Rural Medical Services and the Bebé Sano program were experiencing fiscal repercussions due to TennCare. The most visible repercussions were on four levels: reduction of Medicaid reimbursement, patient dumping by private physicians, the loss of emergency medical care payments, and undocumented migrant farmworker's status.<sup>38</sup>

The traditional state/federal Medicaid program deeply discounted Medicaid payments to providers, but TennCare cut these payments even further. Rural Medical Services immediately

realized severe reimbursement reductions for all Medicaid services provided at the community health centers. There was no recourse in recouping these funds.

The Medicaid payment reductions created a local ripple effect. Private physicians, including specialists, began dropping their Medicaid patients in direct response to TennCare reimbursement rules. Many of these patients were reassigned to community health centers. Thus, Rural Medical Services was required to absorb new Medicaid patients—many of whom required complex medical care due to multiple chronic conditions.

To further complicate dwindling resources, TennCare did not provide care to temporary residents, such as migrant farmworkers. Migrant farmworkers who possessed Medicaid cards from other states were not automatically qualified for TennCare. All new residents to the state were required to apply for TennCare, a relatively lengthy process for migrant farmworkers. According to the migrant program medical director and the CEO, many migrants left the area before they received their TennCare approval, another direct source of lost revenue for Rural Medical Services.

Immigration status further exacerbated the declining fiscal state of Rural Medical Services. The program coordinator estimated most of the migrant women served by the Bebé Sano program were undocumented, and there was no recoverable Medicaid payments for undocumented migrant farmworkers. Under the traditional Medicaid system there had been a provision which paid for emergency care, including migrant OB deliveries, regardless of their citizenship status. TennCare did not incorporate this provision by design.

Bebé Sano had approximately 14 unfunded deliveries for the 1994 migrant season (interview with migrant medical director 1995). The unfunded deliveries translated to no

reimbursement for hospital and physicians' services rendered. Fourteen babies represented a large loss of revenue.

### **Sliding scale fee**

Several personnel pointed out that Bebé Sano's services were not free, but were "discounted" from the clinic's usual charges. Many of the personnel referred to a sliding scale approach based on patients' income for discounting fees. A flyer distributed to migrant locales made it explicit that the Bebé Sano program charged migrants who had no form of insurance, as well as those who were undocumented, a flat fee of \$15 for a clinic visit and a minimum of five dollars for laboratory tests. The flyer read, in part:

LOS SERVICIOS NO SON GRATIS, PERO DAMOS UN DESCUENTO A LOS TRABAJADORES AGRÍOLAS Y SUS FAMILIAS.

[The services are not free, but there is a charge for farmworkers and their families.]

SI UD. TIENE SEGURO MÉDICO, NECESITA TRAER SU TARJETA O PAPELES CUANDO VIENE A LA CLÍNICA.

[If you have medical insurance, you need to bring your card or papers when you come to the clinic]

SI NO TIENE SEGURO MÉDICO (MEDICIAD, TENNCARE, U OTRO), PEDIMOS QUE TRAIGA DINERO CADA VEZ QUE VIENE.

[If you do not have medical insurance (Medicaid, TennCare, or other), you must pay cash each time you come.]

CADA CONSULTA: \$15

[The cost of each visit: \$15]

CADA ANÁLISIS: \$5 - \$10 MIMIMO  
(ANÁLISIS DE SANGRE, ORINA, O CUALQUIER OTRO TIPO)

[Each laboratory test (blood, urinalysis, or other): minimum of \$5 - \$10]

The fees required for migrant services provided some revenue for the community health center. In reality, the monies received from migrant farmworkers were an insufficient source of revenue for Rural Medical Services, and to the migrant farmworkers it was vastly expensive.

### **Grant funding**

Grant support for the Bebé Sano program had been sporadic and relatively small. In 1994, there were two grants specific to the program: (1) East Coast Migrant Health Project, an organization based in Washington, D.C., provided in kind support of one full-time outreach worker and one half-time health educator; and (2) the Quaker Oats Company provided a small one-time grant for maternal child health education material to be distributed in the community. In 1992 and 1993, the program had received a grant from the March of Dimes for general operating expenses. However, for the 1994 funding cycle, the organization had missed the submission deadline for renewing the grant, thus exacerbating the program's fiscal distress. At the time of the site visit, the program coordinator had submitted a grant proposal to the March of Dimes for funding in 1995. This grant, if accepted as proposed, would be in the amount of \$2,225. As pointed out above, one of the program coordinator's major functions was grant writing, and she had located several possible sources for future funding.

### **Community Support and Opposition**

The Bebé Sano program had overwhelming support from Rural Medical Services and their providers. The program's staff, in particular, was very committed to serving this special population. All of those interviewed communicated a deep sense of dedication to the services they provided. Several expressed an essential need to protect and defend migrants and their right to access the program's services. One staff member (1995), with deep concern, quietly shared with us that the doctor serving as the migrant program medical director had discontinued the evening migrant clinic, severely limiting their access to medical care.

The community at large was less accommodating, however. The project originally met with strong resistance from the community, particularly in the sense of providing services to outsiders. One migrant farmworker interviewed in 1995 in a similar context (a predominately white community west of the catchment area) bitterly remarked that the local people wanted them in the fields, but not in their grocery stores. Cocke County and much of the rural areas in the catchment area demonstrated a closed Appalachian community culture, a community that would not accept easily the admittance of outsiders.

In 1985, some of the Rural Medical Services' board members and other community members were particularly concerned that the Mexicans would settle in the area, taking their jobs. Nearly ten years later, there was little proof that the Mexicans were in direct economic competition with the local population, but there was a definite Mexican presence in 1990 (Table 4-2).<sup>39</sup> The CEO, said "it's never, never been proven to be the case." It appeared that the community resistance runs far deeper than a fear of economic displacement.

At the time of our visit, the program continued to suffer from community resistance and racism. In 1994, a Knoxville television station (Channel 10) did an exposé series detailing the plight of migrant farmworkers and their families in an attempt to raise community awareness among the dominant white population. Two episodes of the series were aired during our site visit.

According to the migrant program medical director, many of the patients accessing the Parrottsville clinic were not supportive of the services provided to the migrant population. As he described the situation in 1995, the local community population expressed a sense of competition. Many were antagonistic about special clinic hours for migrants, having to wait in the same waiting room with "Mexicans," and a general displeasure sharing their clinic with

aliens. One of the repercussions of their displeasure resulted in discontinuance of evening hours for farmworkers and their families, a critical point of access for migrants. Community resistance to migrant farmworkers and their families was a clear indicator of a powerful barrier to the Bebé Sano program and will be explored further in the following section.

## **Evaluation**

The Bebé Sano program coordinator, in her short time with the program, had developed two evaluation tools (as proposed in the 1995 March of Dimes grant application). One tool relied on a new data entry program, one which would collect discrete data on obstetrics (OB) migrant encounters. The statistics collected were to be comparative to evaluate changes in the usage patterns of migrant OB clients. The 1994-1995 agricultural season was the first year of data collection. There were eight components for comparative analysis: (1) number of prenatal clinic encounters, (2) number of OB visits per patient, (3) number of migrant women accessing care for the first time in the third trimester, (4) number of missed appointments, (5) number of OB referrals provided to pregnant women leaving the area before delivery, (6) number of newborns receiving a clinical exam within the first month, (7) number of ill newborns seen in the first month, and (8) number of OB migrants receiving WIC and eligible for Medicaid. At the time of our visit, there were no comparative data available to review.

The second evaluation tool was still in an early stage of development. That tool was an “OB Questionnaire,” or survey, designed to assess multiple areas of the program from the perspective of the client. The questionnaire, administered verbally in Spanish, included open-ended and closed-ended questions. Many of the questions were multi-part, for example one question (number 4) queried the patient’s understanding of health education materials: “Did you understand the written information we gave you about pregnancy, childbirth, etc? Did the information answer your questions? What materials were most helpful? Were there any

materials that were confusing or not helpful?” One of the planned uses of the prospective data was to strengthen grant proposals. Lack of such data had been a major barrier in securing grant funds.

### **Barriers to Care**

The design of the Bebé Sano program and its staff had addressed the most common barriers to care for migrant women traveling with their husbands outside of their home base, such as language, outreach, translation and interpretation, transportation, and providing care regardless of their ability to pay. And, yet, other barriers remained. For this solitary clinic, the reality of providing perinatal care to migrant women was intertwined with deep-seated issues within processes of politics, economics, and ethnic differences. The most prominent barrier remained the processes of politics and economics at the national, state, and community level. Therefore, TennCare will be discussed further—at times, through the voices of the organization—to highlight some of the complexities of these processes.

### **TennCare**

Tennessee unveiled a new state Medicaid program, TennCare, in January 1994. TennCare is a complicated, mammoth program; therefore discussion of it will be limited to its early impact on the Bebé Sano program. The new Medicaid program was designed as a managed care program administered through private insurance companies (managed care organizations) with state oversight. By the time of the site visit in August 1994, health care in Tennessee, including the community health centers, was feeling the effects of the new program.

The program was highly controversial from the moment of its introduction. One of most controversial issues of the program was payment reimbursement to practitioners. The cuts were so severe that many private physicians, including specialists, dropped their Medicaid patients. Medicaid patients were “reassigned” to local community health centers, dramatically increasing

Rural Medical Services' case load. In terms of Rural Medical Services' three small community health centers, the effects meant more patients with lower revenue. In 1994, Rural Medical Services' budget was 1.6 million, a relatively modest budget to run three clinics. In a very short space of time, Rural medical Services' community health centers were seeing more chronically ill patients with medical issues such as: cardiac disease, hypertension, and diabetes to name only a few.

The CEO said they were “absolutely swamped” in terms of patients—with no increase in federal funding. At the time of our visit, Rural Medical Services did not receive federal funding for the *Bebé Sano* program under the Migrant Health Centers Program (MHC)—commonly referred to as 329 funding, even though the Parrottsville community health center was designated by the federal government as a Migrant Health Center in the 1994 Migrant Health Centers Referral Directory (National Resource Program 1994). As noted earlier, the organization did receive 330 federal funding for Community Health Centers administered through HRSA's Bureau of Primary Health Care.<sup>40</sup> The CEO stated that to obtain 330 funds, “Every year we have to submit a grant to our regional [HRSA's Atlanta] office. We receive approximately 40% of our total budget in the form of a [HRSA 330] grant.”

When asked why they did not receive federal funds for their migrant program, the administrator explained that, “We will see anywhere—depending on how actively we go out and count heads. And that's what it is—a numbers game. Technically you're supposed to see 4,000.” In terms of a Migrant Health Program grant, it was the responsibility of the grantee to count the number of migrant farmworkers in its catchment area. In reality, this is a very difficult task given the reluctance of many migrant workers to be located and questioned. Rural Medical Services, running on a modest budget, had limited resources in terms of personnel and time to

accomplish the task. In his estimate, there were approximately 1,500 to 2,500 migrants in the catchment area, very likely a low estimate given the size of the catchment area.

Returning to the issue of 330 funding, 330 funding was a key component of Rural Medical Services' sustainability not only for the funds the grant provided, but also for the status it engendered. Any community health center receiving 330 funding was automatically granted the distinction of *Federally Qualified Health Center* (FQHC) by the federal government. The FQHC status qualified Rural Medical Services to treat and care for Medicaid and Medicare patients under state and federal programs. This was no small point. Medicaid and Medicare revenue was a significant portion of their budget. Thus, FQHC status was key to Rural Medical Services' sustainability.<sup>41</sup>

The CEO provided a deeper insight into the importance of having FQHC designation. At the time, he was the President of the Tennessee Primary Health Care Association, and he watched from this position as TennCare was unveiled. In his words, "Speaking of the 1115 Waiver [which led to the creation of TennCare], NACHC [National Association of the Community Health Centers] in Washington filed a federal lawsuit challenging a specific part of the 1115 Waiver: waiving the FQHC provision of the Medicaid law, which says that Federally Qualified Health Centers, such as ours, were supposed to be reimbursed at reasonable costs. And [the state] *they waived that*: one branch of the government [state] is saying your [federal] rules do not apply to us in our situation."<sup>42</sup>

The CEO explained how TennCare further impacted their organization, ". . . in all the planning, there was not one thought about the migrants. Before we could get migrants—especially migrant OBs—covered through emergency [care] . . . and we would get the hospitals some money and some delivery money for us because we receive no [329] federal funds. . . . but

TennCare completely—they wouldn't even acknowledge that migrants come through Tennessee.”

From another perspective, the migrant program medical director (1995) expressed a pragmatic, vivid account of Medicaid funding issues and the tension between the community and migrant farmworkers from his clinical perspective. His narrative powerfully presents the linkages and the complexities of political, economical, and ethnical processes at multiple levels.

Unless otherwise noted, the following viewpoint was that of the migrant program medical director in 1995, one year after the original site visit. At the time of the interview, TennCare had been in place for 20 months, and problems remained with the program. As a result of TennCare, the doctor had become increasingly involved with the Tennessee Primary Care Association and the Tennessee Medical Association vis-à-vis the politics of the state program. A catalyst for his (and many others) entry into the politics of health care was a direct result of how TennCare was planned and implemented. TennCare was planned behind closed doors with little input from major stakeholders including the Tennessee Hospital Association, Tennessee Medical Association, and the Tennessee Primary Care Association. To further enrage major stakeholders, Tennessee State Legislation approved TennCare with little debate and no public hearings (Gold, Frazer, and Schoen, 1995:5).

The interview took place during the migrant program medical director's lunch break, and he purposely directed the interview—allowing us little room for questions. He had been apprised of our visit and our intent to follow-up on the *Bebé Sano* program. The tone of the interview was not that of a dialogue but of a commentary. The physician clearly had an agenda, mostly to demonstrate the extreme difficulties in providing care to an alien population as well as the grave deficiencies of the TennCare program.

We just don't have the funding, so we are kind of doing this [migrant] program and never really able to define what exactly we're supposed to be doing.<sup>43</sup> We are doing the well child care and whatever [the Bebé Sano program] . . . so at this point that's kind of where we're at. We, we've never really defined what our goals are. We try to provide total health care to all of the migrants. At this point, short of getting more funding and more personnel, we can't do that. And as our clinics are getting busier, we'll see . . . more, we'll work them in. . . .

In the above passage, the migrant program medical director reiterates the findings of our 1994 visit; too many patients with insufficient funding.

In 1994, the CEO had referred to this doctor as the migrant program medical director, but had not explained what this title entailed. At that time, it appeared his position was an organizational title overseeing the Bebé Sano program, and we did not question the CEO in detail regarding the duties of the migrant program medical director. During the 1994 site visit, the Migrant Program physician was available for only a short introduction and a few brief questions. However, from the 1995 interview, it is clear the Migrant Program included a larger scope than just the Bebé Sano program, but without a formal program design.

The migrant program medical director continued with more detail on funding issues.

It's been our problem with the [adjacent county] hospital, you know, is about their providing prenatal care . . . or whatever, because they don't feel comfortable about that because they just don't speak the language, so we provide the prenatal care and then when the patient goes into labor and shows up at the hospital [in the adjacent county], and the hospital calls us up, and the doctor there is mad at us, 'why are you sending your patients over to here?' Because they have no idea [that the patient] comes to us [for prenatal care] and they live right next door [to the adjacent county hospital]. A lot of them live walking distance to the . . . hospital, but are having to come twenty miles away [for treatment at the Coker County Hospital]. . . .

What the physician described equated to geopolitical turf wars; county hospitals outside of Coker County evading care to migrants residing within their own county. Each of the five counties in the catchment area had at least one hospital. To the migrant families in the catchment area, geopolitical boundaries had vague meaning. County lines essentially were invisible to most migrant farmworkers. Hence, migrant women in labor sought the closest hospital from their

home. However, for the surrounding counties in the catchment area, the crossing of county lines for hospital care had fiscal repercussions.

The hospitals surrounding Cocke County simply were not willing to accept responsibility for delivering babies from the *Bebé Sano* program. “Not speaking the language” was not the core reason outside county physicians were “mad” at Rural Medical Services’ doctors when migrants arrived at their hospitals. More compelling was the loss of revenue, for (as discussed above) TennCare did not reimburse hospital and doctors for migrant farmworkers whom were ineligible for Medicaid, and for those migrants who did qualify for Medicaid, the delivery of Medicaid babies simply was not profitable for the hospitals. Table 4-7 provides a comparison of Cocke County’s hospital resources and charity care provided and the other four counties in the catchment area.

Cocke County provided more charity care than all six surrounding hospitals combined (4.9% versus 3.5%) even though Cocke County’s solitary hospital was among the smallest in the catchment area. Rural Medical Services took on the financial burden of providing perinatal services to all migrants in the catchment area with no visible support from the surrounding counties at time of delivery.

The migrant program medical director continued,

The [Cocke County] hospital is starting to say ‘wait a second. We’ve got some limits on the amount of indigent care that we can provide and the limits our catchment area [can provide].’ And they’ve [the Cocke County hospital] never really made a big point about it, but seeing as how funding has become increasingly bad, it’s going to reach the point—well the hospital, the whole hospital system in Tennessee [is] . . . it was easier when Medicaid was paying 50 cents on the dollar. Now Medicaid [TennCare], at least for a hospital in this [area], is paying 15 cents on the dollar. They [Medicaid] went from 48 [cents on the dollar] to 15 [cents on the dollar with the implementation of TennCare]. That’s why we can’t afford to run [migrant health services]—so at this point, they’re beginning to look at any place they’re [the hospitals] having [financial] loss. And it’s starting to get more critical. And this is not only for here; it is happening all across the country.

The physician had told us earlier that the clinic still had 14 migrant deliveries that had not been funded for the 1994 season, putting a financial strain on the clinic as well as their local hospital. Furthermore, his estimation of what the state Medicaid program reimbursed health care agencies for patient care services was indeed quite dramatic and relatively accurate at the time. The Medicaid reimbursement rate has dropped substantially since TennCare was instituted in Tennessee in 1994.

Returning to the doctor's narrative, who was interviewed in 1995—nearly a year *before* the Welfare Reform Act was passed. He continued,

. . . as it stands now, I'm watching what's happening with Medicaid. This is not migrants—this is Medicaid in general and welfare. The Michigan welfare system clamps down on the Michigan people on welfare: 'You're going to go back to work in five years,' or whatever, or Connecticut, or New Jersey. And then, all of a sudden, we have this influx of people coming to Tennessee. They're moving from one state to another. So I can see this happening: we have a block grant [from the Federal government] and which every state that tends to try to be the best in taking care of their own people, you're going to see an influx into that state. . . .

Once again, stepping outside of the doctor's narrative, he was speaking of a case where one of his non-migrant patients on TennCare came in with a broken ankle, and the physician had a difficult and frustrating time finding an orthopedic doctor to take care of her. Once the clinic physician found an orthopedic doctor to accept and treat her, it was several days until the orthopedic doctor could actually see her. The exasperated doctor pointed out to us,

How do you deal with a system . . . a Medicaid system that was supposedly responsible didn't [take care of the patient], and the problem is compounded with the migrants because [of] the Medicaid system, supposedly the state is on the lookout for these patients; there's a network of people, of providers, but with migrants, there's no network of providers, so there's us, and we are first level and last level, we are the only level. And now that the hospital is starting to also turn around and question, especially our out-of-county people, we are put on the defensive. . . . Our hospital here complains why are we bringing [another adjacent] county patients from [their] county to [our] county, and [the other] county hospital is complaining, 'why did you let the patient that you've seen in the clinic come to our hospital?' When they [the patients] live near that hospital, and they're in labor and don't have, you know, [the transportation, the time to come to us]. So it becomes a bit of a problem.

## Racism and ethnic hatred

Later in our conversation, the doctor touched on a sensitive community issue; he describes the antagonistic tension that has developed in the local community:

We have had patients, non-Hispanic patients, complain about all the Spanish speaking people in the waiting room and stuff. Patients say, ‘you know I really don’t like sitting in the waiting room with all of those Mexicans.’ And then, the next thing I know is they don’t come back any more; they go to some other clinic. . . . I don’t think just having an all Spanish clinic day is the answer either. So we try to keep it integrated. When we had an evening clinic [for the migrants], that was a source of tremendous irritation by the community [emphasis in the original]. [Without realizing it, I found myself saying to the doctor, ‘really?’ And he continued,] Well sure. A school teacher calls up and says ‘wait a second; this isn’t fair. I call up, I work until five o’clock at school, and I want to be seen in the evening. You tell me I can’t, then a Mexican walks in at five o’clock and you see him. That’s not fair’.

After our interview with the migrant program medical director, we toured the waiting room. The waiting room was rectangular in design and spacious, and it was as if a line had been drawn down the middle of the floor: Mexican patients on one side of the room and the local “white folks” on the other side of the room.<sup>44</sup> There were Mexican children playing on the floor with toys provided by the clinic. The local children, however, sat in their seats quietly, watching the Mexican children play. It is painfully apparent that racial and ethnic inequality remained prominent in this rural area of Tennessee. Migrant farmworkers working within rural communities in Tennessee represent to the general population not only aliens from another country, but aliens who are not part of the fabric of the rural community.

The physician continued with the common theme of insufficient resources:

We have reached a point where the demand [for migrant health care] has out-stretched the extra resources, you know. We were kind of letting them in [the migrants], letting the rest of the system sort of take up the burden, and you can do that when you are seeing two or three, but when you are seeing ten, or twelve, or fifteen a day, the rest of the system can’t hold, can’t hold. And one of the things that we have been trying to do is, we have taken all of the migrants and put them on, we’ve had a lot of patients on what’s called a sliding scale fee. Our minimal sliding fee is fifteen dollars, which is far and away less than any other clinic. What we have really been trying to push is to say ‘OK, we’ll see you, but you have to pay fifteen dollars.’ And, you know, that’s worked reasonably well. I’m not sure that

amount covers what our overhead is; it certainly doesn't cover our overhead when you tie in that it also covers transportation back and forth. Taxi service is unbelievably expensive. So we have attempted to try, you know, make some kind of—to try to recoup a little bit, but it's . . . in the absence of outside funding, we're really reaching a critical level at some point and having to say, 'well . . . something is going to have to happen in the next couple of years or they're [the migrants] not going to have any access to anything. . . .'

In 1994, this particular clinic logged nearly 1,500 migrant farmworker clinic visits, which is, in all likelihood, only the tip of the iceberg of migrant health needs in the catchment area.

The doctor concluded the interview with,

We are willing to try to define [providing care to migrants] because we have never [turned away migrants], because of this question of funding. We've left everything on hold. We do not have a definition of who are we trying to reach, how we're going to reach, short of saying, 'we are going to get the pregnant ladies, we're going to get the babies, and get them immunized. Other than that, we really do not have a goal statement [for a Migrant Health Program] because we don't have any funding to do anything.

This physician is but one informant, but his words make a powerful statement and expose some of the realities of providing health care to migrant farmworkers. The physician draws a picture of political and economic boundaries at multi dimensions: community boundaries, county boundaries, state boundaries, and national boundaries, all of which are intertwined with the delivery of health care, boundaries that are invisible to the migrant farmworker who flow with the crops. The doctor's narrative directly questions the future viability of the Bebé Sano program.

### **Addendum 2008**

Rural Medical Services has continued clinical care, outreach, and education to migrant farmworkers and their families, according to the CEO (personal communication 2007).<sup>45</sup> According to a reauthorization grant application, dated November 29, 2004, for the continuation of grant funds for the community health center, the organization's annual budget was \$3,803,259; 29% from federal CHC funding and 71% from program income. There was no documentation that the organization received any federal funding specifically for the migrant

encounters (FOIA HRSA document, Application for Federal Assistance dated November 29, 2004).

In 2008, the Hispanic maternal child program, as in 1994, had a medical director, program director, and a bilingual staff (personal communication with Rural Medical Services, 2008). In 2003, Rural Medical Services added a “Lay Health Promotion project” which incorporated five *Promotoras* from the local Hispanic community to assist in outreach efforts (FOIA HRSA document, Application for Federal Assistance dated March 3, 2003). Other efforts and additions to the staff indicate a continued commitment and active efforts to increase cultural competence of the staff as indicated by hiring personnel with many years of residence in Latin America and encouragement of current staff to strengthen linguistic and cultural knowledge with firsthand experience in Latin America. For example, one of the nurse practitioners taught herself Spanish and “has made numerous trips to Mexico to further her understanding of the culture” (FOIA HRSA document, Application for Federal Assistance dated November 27, 2001). As of 2007, four of the five physicians were bilingual. The medical director of the migrant program has recently changed with the departure in June 2007 of the long-standing medical director interviewed in 1995. The new physician was previously a medical missionary in Ecuador.

The Migrant Program has expanded and is more inclusive, providing services to the “Spanish speaking population” (see the agency’s Web-site at <http://www.ruralmedicalservices.org>). Hispanic patients, the program director informed me, are seen at the Parrottsville and Newport clinics, an expansion since 1994. The maternal-child program (referred to as *Bebé Sano* in 1994) has been maintained and supported irrespective of economic and political constraints. Again, this remains an economic challenge in light of the contemporary high poverty rate (22.5%) in Cocke County (U.S. Census Bureau 2007d).

The program name has changed over time morphing from a culturally sensitive title in Spanish, *Bebé Sano*—a name selected to emulate concern for migrant women and their infants passing through eastern Tennessee—to “Increasing Prenatal Care Access and Education for the Hispanic Population,” (personal communication with the organization’s grant writer October 2007). The name transformation is indicative of the agency’s internal struggle to market the program to philanthropic organizations for funding purposes by using key terms such as “increasing,” “access,” “education,” and “Hispanic population.” These trigger words enhance and reinforce the needs of the community in applying for grants. Notice that the term migrant farmworkers is not associated with the title, shifting the need from a more transitory population suggesting a more permanent community population.

The 2000 U.S. census figures suggest there has been an increase in the Hispanic population in the catchment area counties, albeit modest with the exception of Hamblen County where the population went from 0.7% in 1990 to 9.3% in 2000 (U.S. Census Bureau 1993b:16-19; 2007d). In Cocke County, according to the 2000 census, there were 374 persons of Hispanic or Latino origin living in the county compared to 144 in 1990. Of these 374 persons, 227 were from Mexico in 2000 compared to 44 in 1990.

From the perspective of the Rural Medical Services, the increase in the Hispanic population is dramatic. The CEO reported that 67% of the county’s births in 2006 were to Hispanic mothers. Although, the statistic masks how many were from the settled Hispanic population and how many were from migrant farmworker population, the CEO believes the majority are from the settled population (personal communication 2007). As in 1994, there was no accurate count of the numbers of migrant farmworkers passing through the region during the agricultural season. Although the numbers remain high as indicated in a grant application

submitted to HRSA in 2002, stating that 3,503 migrants were tested for tuberculosis between November 1, 2001 and July 30, 2002 through a special outreach project (HRSA FIOA document, Application for Federal Assistance dated November 11, 2002).

Political and economic forces continue to be the most salient issues affecting the provision of health care to migrant farmworkers and their families. TennCare funding remains a daunting obstacle in providing care to the migrant farmworker population in the catchment area.

Notwithstanding the funding issues discussed above, a new state policy has further diminished financial reimbursement for this vulnerable population. It was reported to me that the State of Tennessee has “reinterpreted” the federal emergency care clause included in the Medicaid waiver. Previously, the clause enabled health care providers to administer care in the case of life threatening scenarios without regard to immigrant status, an interpretation which included obstetrical deliveries. Effective January 2007, no Medicaid payments under TennCare will be made on any emergency case unless the person receiving care has a valid U.S. identification. As the CEO pointed out in our conversation (2007), Federally Qualified Community Health Care Centers have never had to screen for immigration status, but are required to provide treatment to all who seek care. He reiterated that they continue to do so; however, area hospitals, in his opinion, will eventually bar obstetric treatment for Rural Medical Services’ migrant farmworker patients.

Migrant farmworkers as alien outsiders, in Tennessee have become a state wide xenophobic political issue and not just an isolated rural concern as Tennessee government officials cast blame on Hispanics as a source of the failure of the state Medicaid system. In 2007, Tennessee State Representative, Donna Rowland—in a televised evening news segment—went on record stating, “every state is a border state” and “every town is a border town,”

referring to the Mexican border (WSMV.com 2007). Her colleague, then State Representative Bill Ketron, who was quoted in the same evening news segment, insinuated TennCare's disenrollment of 300,000 people in 2006 created a situation where Mexican immigrants received health care at the expense of native Tennesseans, "many of whom have lived here all their lives" (WSMV.com 2007). According to the news segment, he said, "it's not fair for people who are here illegally to get [TennCare] coverage that legal residents can't get" (WSMV.com 2007).<sup>46,47</sup>

The program remains sustainable through "folding it into" the agency's CHC budget supported in part by the U.S. Public Health Service administered through HRSA. Rural Medical Services, as it did in 1994, receives 330 funding for its CHC. In 1994 the agency did not qualify for 329 funding for migrant care; however that funding restriction has been somewhat mitigated by changes to the federal law governing funding to CHCs. Since the original site visit, an amendment to the Public Health Service Act, the "Health Centers Consolidation Act of 1996" (Public Law 104-299), has restructured payment provisions to entities providing migrant farmworker health care. The amendment provides payment for migrant farmworkers, and other underserved populations, through the provisions of 330 CHC funding; thus increasing the sustainability of the maternal-child program.

Table 4-1. Selected 1990 Sociodemographic Characteristics for the United States, Tennessee, catchment area population, and Willacy County, Texas.

	Sq. Miles	Density	All persons	White %	African American %	Hispanic %	Rural %
United States	3,636,338	70.3	248,709,873	80.3	12.0	8.8	24.8
Tennessee	41,220	118.3	4,877,185	83.0	15.9	0.6	39.1
<b>Cocke</b>	<b>434.4</b>	<b>67.1</b>	<b>29,141</b>	<b>97.6</b>	<b>1.8</b>	<b>0.5</b>	<b>75.6</b>
Greene	621.8	89.8	55,853	97.2	2.3	0.3	75.8
Hamblen	161.0	313.5	50,480	94.8	4.6	0.7	57.6
Jefferson	273.8	120.6	33,016	96.7	2.8	0.3	83.4
Sevier	592.3	86.2	51,043	99.0	0.4	0.5	63.3
<b>Willacy, TX</b>	<b>596.7</b>	<b>29.7</b>	<b>17,705</b>	<b>78.2</b>	<b>0.5</b>	<b>84.0</b>	<b>49.5</b>

Sources: U.S. Census Bureau (1993a:1,4,6-7) *1990 Census of Population: Social and Economic Characteristics, United States; U.S.*; Census Bureau (1993b:1-2,5-6,9-10) *Census of Population: Social and Economic Characteristics, Tennessee*; U.S. Census Bureau (1993d:57) *1990 Census of Population: Social and Economic Characteristics, Texas; Section 1 of 3*. U.S. Census Bureau (1993e:1,4,6-7) *1990 Census of Population: Social and Economic Characteristics, Texas; Section 2 of 3*. U.S. Census Bureau (1993f:2,5,35) *1990 Census of Population and Housing, Population and Housing Unit Counts, United States*. Washington, DC: U. S. Department of Commerce; U.S. Census Bureau (1992e:1,5-6,7-8) *1990 Census of Population and Housing, Population and Housing Unit Counts, Tennessee*. U.S. Census Bureau (1992f:10,14,29). *1990 Census of Population and Housing, Population and Housing Unit Counts, Texas*. Washington, DC: U.S. Department of Commerce. (Note: Areas in bold indicate persistent poverty county.)

Table 4-2. Percentage of Hispanic population Mexican, 1990, for catchment area counties and Willacy County, Texas.

	Number of persons of Hispanic origin	Number of Mexicans	% of population Mexican
<b>Cocke</b>	<b>144</b>	<b>41</b>	<b>28.5</b>
Greene	163	62	16.3
Hamblen	134	55	41.0
Jefferson	86	19	22.1
Sevier	361	171	47.4
<b>Willacy, TX</b>	<b>17,705</b>	<b>14,879</b>	<b>84.0</b>

Sources: U.S. Census Bureau (1993b:16-19,22) *1990 Census of the Population, General Characteristics, Tennessee*. Washington, DC: U.S. Department of Commerce; U.S. Census Bureau (1993d:57) *1990 Census of Population, Social and Economic Characteristics, Texas, Section 1 of 3*. Washington, DC: U.S. Department of Commerce. (Note: Areas in bold are persistent poverty counties.)

Table 4-3. Selected 1990 socioeconomic indicators for the United States, Tennessee, Bebé Sano catchment area, and Willacy County, Texas.

	Poverty rate %	Per capita income	Unemployment rate %	Educational attainment % <sup>b</sup>
U.S.	13.1	\$14,420	4.1	75.2
Tennessee	15.7	\$12,250	6.4	67.1
<b>Cocke<sup>a</sup></b>	<b>25.3</b>	<b>\$8,574</b>	<b>10.8</b>	<b>50.4</b>
Greene	16.9	\$10,161	7.2	58.1
Hamblen	13.9	\$11,127	6.2	61.6
Jefferson	15.1	\$10,562	7.3	60.5
Sevier	13.2	\$10,848	9.2	61.8
<b>Willacy, TX</b>	<b>50.3</b>	<b>\$4,363</b>	<b>17.3</b>	<b>32.7</b>

Sources: U.S. Census Bureau (1993a:1-3) *Census of Population: Social and Economic Characteristics, United States*. Washington, D.C.: U.S. Census Bureau; U.S. Census Bureau (1993b:1-2,5-6,9-10) *Census of Population: Social and Economic Characteristics, Tennessee*. Washington, D.C.: U.S. Census Bureau; U.S. Census Bureau (1993d:126) *Census of Population: Social and Economic Characteristics, Texas, Section 1 of 3*. Washington, D.C.: U.S. Census Bureau. (Notes. <sup>a</sup>Areas in bold are persistent poverty counties.

<sup>b</sup>Educational attainment, as measured by the percentage of the population 25 years and older with a high school diploma or its equivalency [GED].)

Table 4-4. Selected health indicators, 1992-1994, for the United States, Tennessee, Bebé Sano catchment area, and Willacy County, Texas.

	Mortality rates, all causes <sup>a</sup>	Heart disease mortality rates	Cancer mortality rates	Cerebrovascular disease mortality rates	Suicide mortality rates
U.S.	914.8	303.2	215.9	62.4	12.0
Tennessee	997.1	326.2	223.7	80.4	12.8
<b>Cocke</b>	<b>1,088.4</b>	<b>376.7</b>	<b>256.2</b>	<b>95.6</b>	<b>13.8<sup>c</sup></b>
Greene	1,031.5	387.6	221.2	77.2	15.0
Hamblen	1,046.7	349.9	206.0	161.6	11.5 <sup>c</sup>
Jefferson	984.3	320.3	209.9	77.5	9.2 <sup>c</sup>
Sevier	910.8	353.7	211.8	44.0	14.3
<b>Willacy, TX<sup>b</sup></b>	<b>842.4</b>	<b>288.2</b>	<b>200.0</b>	<b>26.9<sup>c</sup></b>	<b>10.3<sup>c</sup></b>

Source: CDC Wonder 2005a, compressed mortality file 1979-1998. Electronic document, <http://wonder.cdc.gov/cmfi-icd9.html>, accessed June 2005. (Notes. <sup>a</sup> Mortality rates are three year averages, age-adjusted per 100,000, and based on the following ICD-9 codes: diseases of the heart 390-398, 402, 404-429; cancer 140-239.9; cerebrovascular disease 430-438; and suicide 950-959. <sup>b</sup> Willacy County data are based on the white county population. <sup>c</sup> The CDC reported these rates as unreliable due to low death rates for the time period [less than 20].)

Table 4-5. Infant mortality rates and birth rates, 1992-1994 for the United States, Tennessee, Bebé Sano, and Willacy County, Texas.

	Infant mortality rate <sup>a</sup>	Birth rate <sup>b</sup>
U.S.	8.3	15.4
Tennessee	9.3	14.2
<b>Cocke</b>	<b>5.7<sup>c</sup></b>	<b>13.6</b>
Greene	6.1 <sup>c</sup>	11.4
Hamblen	9.4	13.4
Jefferson	7.3 <sup>c</sup>	11.6
Sevier	3.6 <sup>c</sup>	12.9

Sources: Infant mortality rates, CDC Wonder compressed mortality file, 1989-1998. Electronic document, <http://wonder.cdc.gov/cmfi-icd9.html>, accessed March 2008; For U.S. birth rates: CDC, National Vital Statistics System, National Center for Health Statistics. Electronic document, <http://209.217.72.34/VitalStats/TableViewer/tableView.aspx>, accessed October 21, 2007; For Tennessee birth rates: Tennessee Department of Health, Health Information Tennessee [HIT]. Electronic document, <http://hit.state.tn.us/BirthRateDetail.aspx>, accessed October 1, 2007. (Notes. <sup>a</sup> Infant mortality rates are three year averages, per 1,000 live births. <sup>b</sup> Birth rates are per 1,000 women. <sup>c</sup> These data are reported by CDC as unreliable due to deaths lower than twenty in the three year time period.)

Table 4-6. Migrant health status: 20 diagnoses encountered in four migrant health centers in Michigan, Indiana, and Texas.

Rank	Diagnosis
1	Diabetes mellitus
2	Health supervision of infant or child
3	Otitis media
4	Normal pregnancy
5	Acute upper respiratory infection
6	Hypertension
7	Consultation without complaint or sickness
8	Dental
9	Contact dermatitis and eczema
10	Common cold
11	Acute conjunctivitis
12	Strep throat & scarlet fever
13	Inflammatory disease of the cervix, vagina, or vulva
14	Anemia
15	Viral infection, unspecified site
16	Acute pharyngitis
17	Urethra and urinary tract disease
18	Gastroenteritis and colitis
19	General Medical Exam
20	External ear disorders

Data source: G. E. Dever (1991:8) Migrant Health Status: Profile of a Population with Complex Health Problems. Migrant Clinicians Network Monograph Series. Austin, Texas: National Migrant Resource Program, Inc.

Table 4-7. Catchment area hospital resources and percent of charity care provided, 1994.

	Number hospitals	Number staffed beds	% Charity care
Cocke	1	53	4.9
Greene	2	281	1.2
Hamblen	2	302	0.3
Jefferson	1	67	No data
Sevier	1	46	2.0

Source: Tennessee Department of Health (1996:64,124,132,184,316) *Picture of the Present, Part Two, 1994*. Tennessee's Health Series. Nashville: Tennessee Department of Health. (Note: Hospitals are non-federal, Medicaid/TennCare certified.)



Figure 4-1. Appalachian home in Cocke County, Tennessee. (Note: Photograph by Susan Morfit, 1994.)



Figure 4-2. Parrottsville Community Health Center and migrant farmworker health center.  
(Note: Photograph by Susan Morfit, 1994.)



Figure 4-3. Rural Medical Services' transportation vehicle used to transport migrant farmworker women and their children to the Parrottsville migrant health center. (Note: Photograph by Susan Morfit, 1994.)



Figure 4-4. Bebé Sano's Driver-Translator during his birthday party at the Parrottville community health center. (Note: Photograph by Susan Morfit, 1995.)

## Notes

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- <sup>1</sup> Rural Community Health Services, Inc., changed its name in 1995 to Rural Medical Services, Inc.
- <sup>2</sup> In 1992, Cocke County was nationally ranked as the 102<sup>th</sup> county in the country for tomatoes, harvesting 259 acres. By 1997 the acreage harvested of tomatoes more than doubled (USDA, NASS 1999b:95).
- <sup>3</sup> The most predominant ancestries of the catchment area, according to the 1990 census, were Irish, German, English, and Scot-Irish (U.S. Census Bureau 1993b: 192-198).
- <sup>4</sup> The 1990 census documented 891 persons of Hispanic origin in the five counties, or 0.4% of the catchment area population. Native Americans comprised 0.3% of the aggregate population and the Asian population accounted for 0.1 percent.
- <sup>5</sup> The percent of the population living in rural areas in the five counties, ranked highest to the lowest, are: Jefferson 83.4%, Greene 75.8%, Cocke 75.6%, Sevier 63.2%, and Hamblen 57.6%.
- <sup>6</sup> Since the target population for this case study is migrant farmworkers and their families, the review of the social indicators of the catchment area will be brief due to the fact that socioeconomic data for the region does not capture this mobile population.
- <sup>7</sup> Infant mortality rates are three-year averages per 1,000 live births.
- <sup>8</sup> Most of the health care professionals interviewed in 1995 reported that the migrant populations they care for are from Mexico, with occasionally a few farmworkers from the Caribbean and Central America. According to the 1990 NAWS report (DOL 1991: 11, 16), 71% of the surveyed Seasonal agricultural workers were Hispanic. Of the 71%, 65% were Mexican or Mexican descent: 57% were from Mexico and eight percent were Mexican-Americans. When ethnicity was broken down into two the categories of foreign-born versus U.S.-born, 92% of the foreign-born Hispanics were from Mexico.
- <sup>9</sup> Inhabitants of the urban interior average 6.5 years of schooling, while border inhabitants average 7.4 years (Fussell 2004:945).
- <sup>10</sup> Douglas Massey (2000) defines migrant networks, which Fussell alludes to, as: sets of interpersonal ties that link together migrants, former migrants, and nonmigrants in origin and destination areas through the bonds of kinship, friendship, and shared community origin. They increase the likelihood of migration because they lower the costs of movement and therefore increase the expected net returns to migration. Migrant costs include the direct monetary costs of making a trip, the information and search costs paid to obtain a new job, the opportunity costs of income forgone while searching for work, and the psychic costs of leaving a familiar environment and moving to a strange setting. All these costs are reduced when a prospective migrant has a personal tie to someone with prior experience in a particular destination area (2000:69).
- <sup>11</sup> For many indigenous groups, Spanish is not their first spoken language. There is evidence that some Mexican farmworkers speak only their indigenous language.
- <sup>12</sup> The Department of Labor's National Agricultural Workers Survey (NAWS) includes migrant farmworkers and settled, non-migratory workers referred to as seasonal workers. In Tennessee in 1994, clinic providers did not know of any Hispanic settled farmworkers in their catchment area. This observation is supported by the U.S. 1990 census data: there were 74 foreign born persons living in Cocke County, none of whom were from Latin America or the Caribbean (U.S. Census Bureau 1993b:213).
- <sup>13</sup> I was able to locate one study by Carolyn Achata (1993). Her research focused on immunizations for migrant children ages newborn to five years enrolled at a day care center in southeast Tennessee, where "Mexican-American migrant workers arrived to assist farmers with planting tomatoes and pumpkins" (1993:93). The research was conducted in the summers of 1988, 1989, and 1990. Over the three year period, 52.2% of the children required immunizations (193:95).

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<sup>14</sup> This percentage (47.4%) of migrant farmworkers was for the collective time period of 1989- 1995. NAWS reports based on 1989-1990 data report 42% of the agricultural workers were migrants (DOL 1991;DOL 1994). This percentage has remained fairly constant over time. The 2005 NAWS report again reported 42% of the agricultural workers were migrant farmworkers (DOL 2005:ix).

<sup>15</sup> See Gwyther and Jenkins (1998) for a comprehensive literature review of migrant health issues.

<sup>16</sup> It must be stressed that while helpful in providing health data on this elusive population, data from state, migrant streams, and local studies may not be applicable to the migrant population as a whole (Galarneau 1992:30).

<sup>17</sup> In Cameron, the poverty rate for Hispanics was 45.9%, in Hidalgo it was 47.1%, and in Willacy it was 50.3% (U.S. Census Bureau 1993c:1149,1171,1208).

<sup>18</sup> Joel Meister is a professor at University of Arizona College of Medicine, Southwest Border Rural Health Research Center.

<sup>19</sup> Mills and Kwong (2001) in a study conducted in California found Hispanic farmworkers had a greater incidence of leukemia, stomach cancer, uterine cervix cancer, uterine corpus cancer, and brain cancer compared to non farmworker Hispanics.

<sup>20</sup> Enforcement of federal and state housing regulations is the purview of a number of state and local governmental bodies and the responsibilities of each vary with differences in local housing, building, and health regulations (National Advisory Council on Migrant Health 1993:9-14).

<sup>21</sup> Migrants are not sufficiently educated to file official complaints, and often they are unwilling to jeopardize their work status by making a complaint against their employer (personal communication with Migrant Health Director 1995; see also, Chavez 1996). The EPA lacks staff to effectively monitor most migrant camps to insure compliance with federal regulations (National Advisory Council on Migrant Health 1993:64-66). The EPA is an independent federal agency and acts separately from HHS.

<sup>22</sup> As described in Chapter 4, HRSA is one of the agencies of the United States Health and Human Services (HHS), which is directed by the United States Secretary of Health—a cabinet level position under the President. In 1994, Tennessee fell under HRSA's Region IV, which included Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee (HRSA 1994).

<sup>23</sup> The CEO referred to the Public Health Service repeatedly when talking about federal funding and the other matters pertaining to operating rules and regulations. Health Resources and Services Administration (HRSA) is governed in part by the Public Health Act (public law passed in 1946), and the Public Health Service Corps remains headquartered within this mammoth agency.

<sup>24</sup> There were 412 live births in Cocke County in 1994 (Picture of the Present, Part 2 1996:61).

<sup>25</sup> Although the Bebé Sano project has a very limited scope, the Parrottsville community health center does provide comprehensive clinic services to all migrant farmworkers according to a 1994 grant proposal.

<sup>26</sup> This passage is from a grant proposal written by the Migrant Program Coordinator 1994.

<sup>27</sup> On a tour of the community health center, a staff member revealed that the clinic sold birth control pills for five dollars a pack, when available.

<sup>28</sup> TOP provided various services including employment referral, housing referral, and had until 1993 provided a Migrant Head Start Program. At the time of the site visit, the county was searching for another organization to take over the Migrant Head Start Program.

<sup>29</sup> Eligible in this context means women who are in the United States legally.

<sup>30</sup> At least one farmer had built housing for migrant farmworkers near his fields.

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<sup>31</sup> From our observation at the community health center, the migrant patients and their children were not offered snacks or water.

<sup>32</sup> We were given permission to accompany the Program Coordinator to the exam room after the nurse practitioner had completed her exam and assessment of the patient.

<sup>33</sup> According to the CEO, the medical director had a familial connection to the area: his grandmother lived in Johnson City, which was located relatively close to Cocke County. His wife was a National Health Service Corp practitioner, a registered nurse, who had been assigned to Rural Medical Services by the National Health Service Corps for a six month rotation. They met, married, and settled in Newport to raise a family.

<sup>34</sup> The doctor's name was substituted with his title.

<sup>35</sup> The region where they were located was accessible by boat and small aircraft.

<sup>36</sup> The Driver had an identical twin brother who lived in Kentucky. Both brothers had taught themselves Spanish around the same time. Neither knew the other spoke Spanish until sometime later.

<sup>37</sup> Some of the details of the program were drawn from 1995 March of Dimes Grant Proposal written by the Program Coordinator in 1994.

<sup>38</sup> Medicaid did not cover undocumented farmworkers, or farmworkers whose Medicaid eligibility could not be confirmed, for example.

<sup>39</sup> The CEO did remark that some migrant farmworkers had settled out to work in a poultry processing plant in Hamblen County. The processing plant had had difficulty in attracting local residents to do what was considered a very undesirable job.

<sup>40</sup> Community Health Center funding is commonly denoted as 330 funding.

<sup>41</sup> According to the Rural Assistance Center (2007), Federally Qualified Health Center designation provides CHCs certain benefits:

- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at a reduced cost through the 340B Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children program
- Eligibility for various other federal grants and programs

<sup>42</sup> The 1115 Waiver that The CEO referred to was a Federal waiver allowing Tennessee to experiment with the traditional Medicaid system in their state. In this case, the state moved it to a managed care program provided by insurance companies. Tennessee made the rules and the insurance carried them out with some autonomy.

<sup>43</sup> The doctor was referring to the providing care to all migrant farmworkers and their families, regardless of their ability to pay for services. It is worth pointing out again that Rural Medical Services did not receive federal funding for these efforts.

<sup>44</sup> The colloquial reference to people was folks.

<sup>45</sup> The CEO interviewed in 2007 was the same gentleman interviewed in 1994.

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<sup>46</sup> Both representatives were Republican.

<sup>47</sup> Federal legislation enacted in 2005 (Federal Reduction Act) restricted Medicaid enrollment to U.S. citizens only. However, undocumented immigrants enrolled prior to 2006 remain covered unless they leave the state.

## CHAPTER 5 CHILDREN AND FAMILY SERVICES

### **Introduction**

Children and Family Services, Inc. is located in western Tennessee and services a catchment area of four counties: Fayette, Haywood, Lauderdale, and Tipton. The economies of the four counties are based on manufacturing (manufacturing-dependent), and, as defined by the USDA, only two are classified as persistent poverty counties—Lauderdale and Haywood.<sup>1</sup> All four counties are vastly poor and rural, with striking differences between white and black residents, as measured by selected social determinants of health.

### **Sociodemographic and Socioeconomic Indicators**

#### **Selected Catchment Area Sociodemographic Indicators, 1990**

Within the four counties, blacks account for a significant portion of the population, although whites—primarily of Irish, German, and English descent—remain in the majority, albeit a slim majority in some counties, Table 5-1 (U.S. Census Bureau 1993b).<sup>2</sup> The vast majority of the catchment area population live in rural areas, with the exception of Haywood County where just under half (48.5%) of the residents reside in rural locales.

Children and Family Services' target population includes any resident within the four counties in need of their services, although low income and indigent residents are the primary target populations. The agency's facilities are located in Covington (city) within the North-Central region of Tipton County, and as such, residents of Covington and Tipton constitute many of their clients.

## **Selected Catchment Area Socioeconomic Indicators, 1990**

### **Poverty rates**

As one may expect, the highest 1990 poverty rate (27.5%) in the catchment area was in a persistent poverty county—Haywood County (Table 5-2). Tipton County had the lowest poverty rate (20.0%), but nevertheless was significantly higher than the state rate (15.7%). In spite of this high poverty rate, Tipton was not officially listed as a rural persistent poverty county. Lauderdale, the other persistent poverty county in the catchment area, had the second lowest poverty rate (22.4%).

When the data are disaggregated by race and compared, a different pattern emerges. The highest black poverty rate (45.3%) is found in Tipton County—the same county with the deceptively lowest overall poverty rate. In Tipton County, nearly half of the black residents lived in poverty, and pockets of extreme poverty were found throughout the county. As case in point, in Covington city, the county the site of the program headquarters, 64.5% of the black residents fell below the poverty line.

Across the four-county catchment area and at the state level, black poverty rates were more than double that of their white counterparts. The black poverty rate in Tipton County was over three and one-half times higher than for white residents—45.3% versus 12.3%, respectively. In Covington city, the poverty rate for blacks jumped to 64.5% compared to 17.4% for white residents.

### **Per capita incomes**

The 1990 per capita incomes for the four counties fell well below the state level of \$12,255 (Table 5-3). The non-persistent poverty counties had the highest and the persistent poverty counties had the lowest. Tipton County had the highest (\$9,796), and Lauderdale had the lowest (\$8,607).

Comparing per capita income by race reveals blacks living in Lauderdale County had the lowest per capita income (\$5,308), and white residents living in Fayette County had the highest (\$12,986)—slightly lower than the state per capita income (\$13,201). Reflecting the high poverty in Covington city, the per capita income of blacks living in Covington city was the lowest (\$4,263) when compared to county level per capita incomes and two and one-half times lower than white residents living in Covington city.

### **Unemployment rates**

The 1990 unemployment rates (percentage of the population unemployed) for the four counties were significantly higher than the state rate of 6.4% (Table 5-4). Within the four-county catchment area, the unemployment rate was highest (11%) in Lauderdale County and lowest (7.7%) in Tipton County. The unemployment rate in Covington city was only slightly lower, by one-tenth of a percent, than Lauderdale's rate.

When data are compared between white and black residents, the trend that emerges is at least a doubling of black unemployment rates compared to white rates. In some areas the data far exceeded this ratio. In Fayette County the black rate of unemployment (14.3%) was triple that of white residents (4.7%). In Covington city, one-fifth (21.5%) of the black work force was unemployed, nearly four times the rate (5.9%) of white residents.

### **Educational attainment**

Educational attainment, as measured by the percentage of the population 25 years and older with a high school diploma or its equivalency (General Educational Development [GED]), is lowest for blacks in the state and the catchment area (Table 5-5). Considering the aggregate (total) population for the state, the four counties, and Covington, educational attainment for the catchment area in 1990 was lower than the state level of 67.1%. Over 40% of the counties' residents, with the exception of Tipton County, did not have a high school diploma. Tipton

County had the highest level of educational attainment (61.8%) and Lauderdale County had the lowest (52.1%).

Following the patterns of poverty and per capita income, educational attainment was significantly higher for white residents than for blacks in the catchment area. Interestingly, the highest and the lowest educational attainment rates occurred in Fayette County where 66.8% of the white residents had a high school diploma compared to only 37.7% of the black residents. In Covington city, 39.9% of the black population had a high school diploma compared to 59.5% of the white population.

### **Selected Catchment Area Health Outcomes, 1992-1994: An Ethnoepidemiological Surveillance**

#### **Mortality Rates, All Causes**

Data for mortality rates—unless otherwise noted—were derived from the CDC Wonder data base using ICD-9 codes. The rates are age-adjusted per 100,000 of the noted population using 2000 as the standard population and are three year averages for the years 1992-1994. Three levels of comparison are made for an ethnoepidemiological analysis. First, U.S. national aggregate mortality rates are compared with the state and catchment county rates. Second, mortality rates of black and white populations at the national, state, and county level are compared. Third, high and low mortality rates for black populations at the county level within the catchment area are compared with the national aggregate population, to provide a sense of how much variation was occurring within the target population across the catchment area.

The 1992-1994 mortality rates for all causes were higher than the national rate for the aggregate populations in Tennessee and the four county catchment area (Table 5-6). At the state level, three of the four counties had higher mortality rates than the state level. Only Fayette County's rate was lower at 984.0 versus 997.1 for Tennessee. The highest mortality rates

occurred in the two persistent poverty counties, Haywood and Lauderdale. Tipton County had the third highest in the catchment area.

The identical pattern holds for the white populations, but for black residents in the catchment area a new pattern emerged. At the state level, black Tennesseans had a higher mortality rate compared to all blacks in the United States. At the county catchment area level, white Tennesseans had higher mortality rates than the national white rate. However, black Tennesseans in three out of the four counties in the catchment area had lower mortality rates than the national rate. Only Lauderdale County, a persistent poverty county, had a higher rate than the national rate. Blacks in the catchment area counties—all four—had lower overall mortality rates than the blacks at the state level. Disaggregating the data by race underscores the differences between these two groups in the catchment area. In some case the differences are striking.

Blacks living in the catchment area fared considerably worse than the aggregate national population. Comparing the highest black mortality rate was found in Lauderdale County to the national average, the difference was significant: 1,244.2 versus 914.9 respectively. The lowest black mortality rate (1,058.9) in the catchment area, found in Fayette County, also was higher than the aggregate national rate.

### **Heart Disease Mortality Rates**

Tennessee had a slightly higher heart disease mortality rate than the aggregate national population (Table 5-7).<sup>3</sup> Three counties fared worse than the state aggregate population. Fayette County had a heart disease mortality rate lower than either the state or national aggregate. The other three counties exceeded the state and national rates, with Tipton only slightly over the state rate, but with Lauderdale exceeding the national aggregate rate by 44%.

The heart disease mortality rates for both whites and blacks in Tennessee were higher than their national counterparts. Whites within the catchment area were split: the two persistent poverty counties three counties (Haywood and Lauderdale) and Tipton County had higher heart disease mortality rates than both the U.S. and Tennessee whites, while Fayette County whites fared somewhat better than both the state and national populations.

Blacks in two counties had heart disease mortality rates lower than the national rate for blacks, and three of the four counties had rates lower than the state rate for blacks, Lauderdale County being the lone exception. For both white and black populations, the highest heart disease mortality rates consistently fell within the persistent poverty counties (Haywood and Lauderdale). White heart disease mortality rates were consistently better than their black counterparts except in Tipton County where the black population fared significantly better than the whites.

Tipton County had the lowest black heart mortality rate of the four counties—Lauderdale had the highest. Tipton County's black heart disease mortality rate was slightly lower than the national aggregate, while the Lauderdale heart disease mortality rate was nearly half again higher than the aggregate national rate.

### **Cancer Mortality Rates**

Tennesseans, in general, fared worse than the general public nationwide. Even when the data are disaggregated by race, national cancer mortality rates for whites and blacks were lower than the Tennessee rates (Table 5-8).<sup>4</sup> Within the catchment area, Fayette County had an aggregate cancer mortality rate lower than either the state or national population. The other three counties had rates significantly higher than both the national and state rates.

Whites within the catchment area had higher rates than whites at the national state level, with the exception of Fayette County. Haywood had the highest white cancer mortality rate within the catchment area.

Blacks in the catchment area fared slightly better compared to their national and state counterparts. Two counties (Fayette and Haywood) had lower rates than the national cancer rate for blacks, and three counties demonstrated lower rates than the state rate for blacks.

Lauderdale County was the only county that equaled the state cancer mortality rate for blacks. Lauderdale and Tipton Counties had the highest cancer rates for blacks in the catchment area.

However, when the cancer mortality rates for catchment area blacks are compared to the aggregate national rate, they remain higher than the overall U.S. population. The highest cancer rate in the catchment area (Lauderdale) was 36% higher than the aggregate national rate. The lowest black cancer mortality rate (Fayette County) was only slightly above the national rate.

### **Cerebrovascular Mortality Rates**

Tennessee's cerebrovascular mortality rates were considerably higher than the United States rates (Table 5-9).<sup>5</sup> All of the catchment counties had higher rates than the aggregate national rate. Two counties (Fayette and Lauderdale) had higher rates than the Tennessee aggregate rate. The rate in Fayette County was twice the aggregate national rate.

The cerebrovascular mortality rate for white Tennesseans was 27.3% higher than for whites at the national level. Whites within the catchment area had vastly differing rates. Three of the catchment area counties (Fayette, Lauderdale, and Tipton) had higher rates than the national average for whites. The white cerebrovascular mortality rate for Haywood County was unreliable due to a low number of deaths from cerebrovascular disease in the three-year period, and any conclusion based on this single data point would be suspect. Within the catchment area, two counties had higher rates than the state rate. Ironically, whites in Fayette County had the

highest cerebrovascular disease mortality rate—higher than any of the black rates and 127% above the national rate for whites. The cerebrovascular disease mortality rate for whites in Tipton County was lower than the state rate for whites.

The pattern of cerebrovascular rates for blacks was slightly different than their white co-residents. Blacks in all four catchment area counties had higher rates than blacks at the national level. At the state level, one county (Fayette) had a higher rate than the state rate, one county (Haywood) tied the black state rate, and two had lower rates (Lauderdale and Tipton). The lowest cerebrovascular disease mortality rate for blacks was also found in Tipton County. Blacks had higher cerebrovascular mortality rates than whites except in Fayette County where the rate was significantly lower than the rate for their white counterparts.

The catchment area cerebrovascular mortality rates for blacks were considerably higher than the aggregate national. The highest black mortality rate due to cerebrovascular disease, in Fayette County, was 81.3% higher than the aggregate national rate. The same pattern of very high rates held true in all four counties, with the lowest rate, in Tipton County, standing at 52.1%.

### **Suicide Mortality Rates**

The aggregate Tennessee suicide rate was higher than the U.S. rate, but not significantly (Table 5-10).<sup>6</sup> Data for the catchment area counties seemed to be fairly consistent with the state and national rates, but the number of suicides in the counties were too low to produce reliable data. Suicide rates among the black population were much lower than in the white population both nationwide and across Tennessee. The data for the catchment area, although unreliable due to low numbers, seem to be consistent with this pattern. The lower rates of suicide among the blacks may reflect cultural differences.

### **Infant Mortality Rates, 1992-1994**

Infant mortality rates in Tennessee were higher than the national average (Table 5-11).<sup>7</sup> Comparison of the U.S. and Tennessee infant mortality rates to the catchment area rates is problematic. Infant mortality rates at the county level were unreliable, except for Tipton County's aggregate rate, due to low number of infant deaths. Tipton County's aggregate infant mortality rate was 14.8 per 1,000 live births, significantly higher than the state rate and 78.3% higher than the aggregate national rate. Although data were unreliable, the available data seem to suggest that Fayette and Haywood Counties had similarly high infant mortality.

The aggregate state white infant mortality rate was slightly lower than the aggregate national rate for whites, while the aggregate state black infant mortality rate was slightly higher than the aggregate national black rate. The black infant mortality rate, however, was more than double the white infant mortality rates at both the state and national levels. The limited, unreliable data at the county level seems to be fairly consistent with this pattern.

The Tennessee Department of Health (2008) ranked Tipton County fifth in the state for its overall high infant mortality rate for the years 1992 to 1994. For the same period, Tipton County ranked first in the state for black infant mortality. Comparatively, for white infant mortality rate, Tipton ranked 13<sup>th</sup> in the state. Black infant mortality rankings for the remaining three counties in the catchment area were the following: Fayette, 8<sup>th</sup>; Haywood, 22<sup>nd</sup>; Lauderdale, 14<sup>th</sup>.

### **Catchment Area Birth Rates, 1992-1994**

The 1992-1994 birth rates for the catchment area ranged from a high of 21.9 per 1,000 women of child bearing age in Tipton for black females to a low of 12.8 per 1,000 women in Haywood for white females (Table 5-12).<sup>8</sup> Distinguishing between black and white birth rates, birth rates for blacks were consistently higher than birth rates for whites within the catchment area. However, white females in the catchment area had higher birth rates than the state rate in

three of the four counties. The white birth rate for Haywood was slightly lower than the state rate. In contrast to the whites, black catchment area populations tended to have lower rates than the state birth rate for blacks, with the exception of Tipton County.

### **Catchment Area Adolescent Fertility, 1992-1994**

In this case, there is a strong emphasis on adolescent fertility rates since Children and Family Services had developed specific programs to address the high adolescent pregnancy and birth rates among black youths in the catchment counties (Figure 5-1).<sup>9,10</sup> Comparing adolescent pregnancy rates (per 1,000 females aged 10-17) before the agency was established 1983-1985 to adolescent pregnancy rates at time period of the site visit 1992-1994, the general trend for white adolescents was a slight increase over time. The trend for black adolescents, on the other hand, was mixed—Fayette and Haywood counties experienced significant increases while Lauderdale and Tipton counties—the two counties primarily served by the program—experienced slight decreases in adolescent pregnancy rates. Lauderdale had the sharpest decrease from 46.5 to 41.5 per 1,000 females aged 10-17 years; Tipton’s decrease was more modest decreasing from 41.9 to 41.1 per 1,000 females 10-17 years.

Examining adolescent pregnancy rates from 1992 to 1994 (three year averages) there was a dramatic difference between whites and blacks (Table 5-13). The highest adolescent pregnancy rate was recorded for black adolescents in Haywood County, which was 168% higher than the white rate for that county. The lowest aggregate adolescent pregnancy rate was in Fayette County. In comparison, the lowest rate for blacks was also in Fayette County, but this was still much higher than the white adolescent rate anywhere in the catchment area.

### **Health Care Resources**

Historically, the counties within the catchment area have been federally classified as Medically Underserved Areas (MAUs) (HRSA 2005 BPHC MUA/MUP database).<sup>11</sup> All but

Tipton County had a shortage of primary care physicians, and all counties lacked mental health care providers (HRSA Health 2005 Professional Shortage Areas database). Fayette and Haywood were each served by a federally funded community health center, Tipton and Lauderdale Counties were not. Comparing the status of basic health care resources in the four counties, as of 1994, Fayette County had fewer resources than the persistent poverty counties (Haywood and Lauderdale).<sup>12</sup> In 1994, generally, Tipton possessed the most health care resources in the catchment area, while Fayette had the least (Tennessee Department of Health 1996).

Ironically, Fayette's health outcomes were, for the most part, more favorable than the other counties in the catchment area, even though the county had fewer resources, second highest aggregate poverty rate, and was classified as 100% rural (U.S. Census Bureau 1993b).<sup>13</sup> When compared to Tipton County, Fayette demonstrated a higher level of positive health outcomes for most health indicators than Tipton County, even though Fayette had a higher concentration of blacks (44.2 % versus 23.6 %). One explanation may be that Fayette had a lower black poverty level than Tipton, 37% compared to 45.3% in Tipton. The observation could also result from the presence of a community health center serving the black population in Fayette. The high concentration of impoverished blacks in Covington City within Tipton County (64.5 % of blacks in the city were poor), may also have contributed to the lower health outcome performance in Tipton County.

### **Agency History: "Building of a Dream"**

In this case study, the successful rural program is an entire agency: Children and Family Services, Inc. Children and Family Services comprised multiple components and programs, with linkages that enhanced and complemented one another. The Enrichment and Intervention Services program targeting handicapped children, the first program offered at the agency, was a

stepping-stone to access other vulnerable populations in the community. As the name of the agency suggests, program participants were not isolated individuals targeted for interventions. Rather, the agency took on a more holistic approach which involved the entire family when possible. Isolate of just one program within the organization for examination would provide an incomplete picture of the agency's success.

The agency sprang from recognition of critical community needs by concerned of civic-minded community members. With a government employee, a social service maternal-child outreach nurse, discovered that disabled black children lacked access to preschool or day care services in the Covington area.<sup>14</sup> After exploring the issue further, the outreach nurse verified that of the eleven private day care facilities in the area—many of which were church-based centers—none would accept a handicapped black child, and, to her surprise, they would not accept *any* black child. The date was 1982, and the outreach nurse was incensed that such a vulnerable population, many of whom were poor, lacked access to pre-school services.

Underlying the outreach nurse's concern was the bleak statistical reality that the aggregate poverty levels in Covington were the highest in the county. Nearly 73% of the city's residents over the age of 25 did not have a high school diploma or GED, and nearly a third of the families were headed by single mothers—60% of whom fell below the poverty level. In fact, over half of all children under the age of 18 lived in poverty. For blacks living in Covington, those statistics were far worse: the majority lived in poverty; black residents were far less likely than white residents to have a high school diploma; the unemployment rate for blacks was six times the rate of white residents; over half of all black families were single mothers—70% of whom fell below the poverty level; and nearly 80% of all black children lived in poverty compared to 21.4% of white children (Table 5-14) (U.S. Census Bureau 1993b:620,680, 699,705).

The outreach nurse was Minnie Bommer, and she was neither indifferent to, nor reticent in confronting, social injustice. In response to the needs of her young handicapped clients, she met with the director of Head Start in Covington, and together they enlisted the help of five other community members from the surrounding areas representing Tipton, Fayette, and Lauderdale counties. “Children and Family Services . . . was an idea—a thought spoken between two service providers over lunch in 1982. From that conversation a community-based, culturally relevant, service oriented economic development Agency was developed” (Bommer 1993). Together they wrote the by-laws, formed a board, obtained non-profit 501(c)3 status, and sought collaboration with state, county, and local organizations.<sup>15</sup>

In 1984, the organization secured funding to conduct a needs assessment, identify local resources, and explore funding sources. The needs assessment confirmed there were handicapped children in the area in need of services, both black and white. By summer of 1985, the first program, Enrichment and Intervention Services (EIS), began service to 15 handicapped children ranging in ages from newborn to four years.

From its conception in August of 1982 to its inaugural operation in August of 1985, Minnie Bommer, who would become the first executive director, worked to secure community support and a physical location to house the agency. But for Minnie Bommer, the quest to provide a community-based organization to help the impoverished became very personal. She described the process of implementing the program as “Building of a Dream” (Bommer 1993).

Minnie Bommer was born in Tipton County, as were her mother and her grandmother. She understood what it meant to be poor and black in Western Tennessee. Bommer’s mother and grandmother were maids, but she was expected to graduate high school—and she did. She

graduated in 1957 from Covington's segregated black high school—in a town (and county) where Jim Crow laws were strictly enforced.

Bommer had vivid memories of living in a segregated world as a child. During a tour of Covington, Bommer pointed out the public library, telling us she was twenty-seven years old before she could walk through its doors. She remembers, as a child, how it felt to walk past it knowing it held knowledge she could not access. “We weren't allowed to use the public library,” she recalled. When she was a very young girl, her mother or grandmother would occasionally take her to town—a very special treat—and she recalled her confusion when she was not allowed to use the public bathrooms or drink from the water fountains marked with signs reading “Whites Only,” having to wait until she returned home to use the bathroom or get a drink of water. At the time, it just didn't seem right to her.

In another recounting of discrimination, one that was both personal and symbolic to Bommer, she explained how the agency acquired their current buildings for the agency. Sometime after school desegregation was instituted, the city debated how to best to utilize the vacant black school (Frasier High School) and its auxiliary buildings. Some town residents wanted it demolished; others wanted to use it as a black recreational facility. The town decided to give the school and the land to the National Association for the Advancement of Colored People (NAACP) to use at their discretion. According to Bommer, soon after the title was transferred to the NAACP, it was fire-bombed (1974)—rendering the primary building useless. The “culprits” were never apprehended. The school's ancillary buildings housed the agency in 1994.

Bommer married right after high school and left Covington with her husband who had joined the military. They soon had two girls one year apart. Bommer described the years she

and her husband traveled with the military, discovering the world beyond Covington, including locations overseas. She found there were choices and opportunities unknown to her in Tennessee—life outside of Covington was different, especially for blacks.

When her husband left the military, they returned to Covington. He wanted her to stay home with the girls, so they moved into the first public housing project, and she “took in ironing.” They moved out of public housing when he took a job in Memphis—a higher paying job, but with a long daily commute.

In the 1960s, Bommer became very active in the Civil Rights movement and joined the NAACP, which eventually earned her the title of “The Trouble-Maker.” She became president of the local NAACP by age of 28, and continued to press for more social-economic opportunities for blacks. In the 1960s there was only one factory in the county—a cotton mill—and it did not hire blacks, so the NAACP fought to bring other industries into the county—industries that would hire blacks.

After a time, she decided to work outside of the home, but was unable to find employment in the Covington area even though she had a high school education, so she took an eight week course in Memphis to become a nurse’s aide, but still “couldn’t get hired.” Finally, in 1967-1968, she went to school to become a licensed practical nurse (LPN). She was one of seventeen in a pilot LPN school offered in Tipton County, and the only black in the class. Her classmates were able to obtain loans locally for their tuition, but not Bommer. She had to go to Memphis to secure a loan. As their training neared its completion, only four of the seventeen students were expected to be hired locally. Bommer graduated second in her class, but had a reputation as a “trouble-maker,” and her instructor said she would not be hired, so Bommer “wrote a letter to the [state] Department of Nursing.” Subsequently, she was hired by the community hospital.

At the time she was hired in 1968, there had only been one other black nurse employed by the hospital. She was fired in 1966 for refusing to eat in the kitchen with the “help.” Bommer also preferred to eat in the employee dining room, and was called in by the hospital administrator, who had hired her, who then suggested she eat in the kitchen. He also reminded her that he had hired her against the recommendations of her instructor, head nurse, and the floor nurse. Bommer declined his request without overt repercussion. Otherwise, she recalls, her conflicts with the staff were minimal. Although she did recall that the nurse’s aides initially refused to work under her (they were white), Bommer said the situation was resolved when she took the matter to the head nurse. She felt her status as black did not diminish her advancement at the hospital because she spoke up when she felt discrimination was involved. Bommer subsequently took a position with the state welfare department at the county level as a maternal-child outreach worker, a position she held for seven years.

Among other civic endeavors, Bommer was a city alderman for two terms—the first black alderman and the only woman to serve in that capacity.<sup>16</sup> We accompanied her to the Covington Board of Mayor and Alderman meeting, where she received an award for her meritorious community achievements. All of the officials were white males except for one black gentleman.

The black alderman and Bommer were often at odds, she explained. He is a county commissioner as well as a city alderman, providing a strong voice for blacks. However, he did not always support Bommer and her agency. When she was trying to secure the old high school building for her fledgling agency—he opposed her—campaigning for the buildings to be torn down. At the time of the site visit he had opposed one of her programs for young males.

To Minnie Bommer, planning and developing the agency was “building a dream.” Her dream to provide members of the community options beyond continued generations of poverty.

In her words, “our philosophy is self-help for community people. . . . Children and Family Services is an example of what can happen when cultural economically disadvantaged people are allowed to decide and implement what they need to become productive, contributing members of their communities” (“The Building of a Dream” unpublished manuscript by Minnie Bommer).

### **Agency Description**

#### **Target Population, Goals, and Objectives**

The agency’s target population and goals were broadly defined in the Children and Family Service’s mission statement and philosophy (unpublished manuscript 1994). The agency operated on the premise that government and nongovernmental agencies were unable to adequately address the needs of the low income families of the community.<sup>17</sup> As a community organization designed and implemented by members of the community, the fundamental goal of the agency was to “to ameliorate the conditions of the disadvantaged and handicapped persons of modest or non income level” (unpublished manuscript 1994). To achieve this goal, the prime objective was to,

Promote ways to educate families, especially the children, to acquire skills, knowledge, and motivation which [will] enable them to become self-sufficient contributors to society. . . . The Agency provides community training and technical assistance to such individuals in an attempt to alleviate such conditions. [unpublished manuscript 1994]

The target populations were the “underserved and low-income families” in Tipton, Fayette, Haywood, and Lauderdale counties. Many, if not most, of the populations served by the agency were from Covington, although several of the agency programs conducted outreach to the neighboring counties and families from the outlying areas in Tipton County. Residents were encouraged to access and participate in the agency’s many services. The agency was located in Covington City, adjacent to the city’s public housing.

## **Agency Organization and Programs**

Children and Family Services was governed by a board of directors. The board members were community members appointed for a two year term with no restriction on the number of terms served. The original seven board members included, “an attorney, Head-Start Director, factory worker, public school administrator, health care outreach worker, college student, and community leader” (Meet TCCES, unpublished manuscript). In 1994, there were 17 board members, 13 blacks and 4 white members.

The executive director of the agency served under the guidance of the board. The by-laws stipulated that the “executive director works for the board,” and although Bommer, as the executive director, ran the agency, she reported to the board monthly, and she stressed that “everything is to go before your board.” Responsibilities of the executive director also included fund-raising, grant and proposal writing, and coordinating evaluations of the agency.

The agency was organized into five divisions or departments: (1) Administration, (2) Pre-School Services, (3) Youth Services, (4) Maternal and Infant Health, and (5) Community Service, with programs divided among the latter four departments. Each of the program departments was headed by a department head who oversaw day-to-day operations. The programs were generally complementary, and often intrinsically related, often overlapping. Minnie Bommer’s philosophy was that once a person entered one of the agency’s programs, the agency’s vast array of services was then available to the entire family. The following is a brief description of the agency’s programs by department.

### **Department of Maternal and Infant Health**

The Department of Maternal and Infant Health coordinated health and social services for low-income women in the catchment area. The department administered three interrelated programs: Maternal Infant Health Outreach Workers, Child Abuse Prevention Services, and

Single Parent/Displaced Homemakers Program. The most extensive and comprehensive of the three was the Maternal Infant Health Outreach Workers program.

**Maternal Infant Health Outreach Workers.** Maternal Infant Health Outreach Workers, introduced in 1986, served high-risk pregnant women. Women identified as high-risk were followed through pregnancy to three months postnatal. For the duration, outreach workers provided education and counseling on a broad spectrum of maternal child issues, including nutrition, parenting, child abuse. The average age of the participants was 16. In 1994 there were 15 women participating in the program, three of whom were 12 years old.

**Child Abuse Prevention Services.** The Child Abuse Prevention Services program (CAPS), introduced in 1994, was a prevention program that included training parents to recognize abusive behavior and methods to prevent such behavior. In 1994 there were 20 participants in this program. However, child abuse prevention was incorporated into many of the programs and services provided by the agency, thus reaching many more than the 20 formally participating in the CAPS program

**Single Parent/Displaced Homemakers.** This program was introduced in 1990, and targeted women in the Maternal Infant Health Outreach Workers program and other clients of the agency who needed assistance in improving their job skills and securing employment. As an example, the agency provided free daycare for women with small children while the mother attended classes to obtain her GED. In 1994 the program had 20 participants.

### **Department of Pre-School Services**

Bommer's philosophy was to bring children into the agency's complex of programs as young as possible sequencing them through age appropriate programs through high school. The programs offered by the Department of Pre-school Services were designed to prepare the children for kindergarten so they could be competitive with their peer group. The department

head of Pre-School Services said children in Tennessee were required to take an “entrance exam” before beginning kindergarten, suggesting that for those children who did not have the opportunity to attend pre-school educational programs, they would enter the school system with a distinct disadvantage. As an example of this point, Bommer told us of a young boy, four years old, who did not speak when he came to them. One day he picked up a book he was interested in and began reading it out loud. In 1994 he was talking as well as reading. Bommer felt if that child had not had an opportunity to attend their program, he would have been placed in a special education class and not identified as the bright child she believes he was.

The Department of Pre-School Services consisted of four programs: (1) Enrichment and Intervention Services, (2) Group Involvement for Toddlers, (3) Child Care Learning Center, and (4) After School Child Care. All of the programs had educational and socialization components appropriate for the target age group. The department head estimated 80% of the children in her programs were from single parent families.

The agency required all participants of Pre-School Services to have proof of immunizations, and Enrichment and Intervention Services (EIS) children had to have a physical examination prior to beginning the program. And while the agency did not provide medical services at the agency, nor had funding for medical services, preschool children were provided vision and dental screenings through local health practitioners who donated their services to the agency.<sup>18</sup> Pre-school children in need of immunizations were referred to the county health department.

The department head for Pre-School Services had worked for the agency for a year and held a degree in Education. She was attending classes for her Master’s degree in Special Education at the time of the site visit. Working with the children in her programs was personally

very rewarding and provided substantive experience for her graduate studies, while—at the same time—her coursework facilitated her ability to work more efficiently with the children.

**Enrichment and Intervention Services.** Enrichment and Intervention Services (ESI) was the inaugural program of the agency, which began in 1985. The program was designed for handicapped children ranging in ages from birth to four years.<sup>19</sup> The program provided service to Fayette, Lauderdale, and Tipton counties with a case load of 18 clients. Referrals came from a wide variety of sources including physicians, county health department, and social services.

The stated goals of the program were “to provide intensive stimulation for toddlers and infants who are at risk for or observed to be developmentally delayed, and to provide guidance for parents of these children in an effort to assist the child to reach his maximum potential” (Meet TCCES, unpublished manuscript). The agency provided parents with an EIS Parent Handbook covering the program’s policies and procedures. Throughout the program, parents were encouraged to participate in different components of the program. As an example, parents were required to attend parent education and training sessions when offered and help in their child’s class on specified days.

Home visits were conducted on Mondays and Fridays by trained outreach workers. Outreach workers used a number of assessment tools when conducting home visits to record progress and to monitor the health status of the child. For example, home visits included monitoring the child’s weight, eating habits, and general health.

On Tuesday, Wednesday, and Thursday, the children came to the center for educational sessions. When necessary, the agency transported the children in agency vans to and from the center. Upon entering the program an assessment using the Early Learning and Accomplishment Profile was completed and very six months thereafter to establish and monitor the child’s

developmental level. For children with speech impediments, the agency worked closely with a speech pathologist who designed lesson plans for the children. In addition to the educational component, sessions conducted at the center were designed to provide interaction conducive to socialization.

**Child Care and Learning Center.** The Child Care and Learning Center (CCLC) began in 1989. It was an educational day care program for children ages 2 to 5 years divided into two age categories (classes), 2-3 years and 4-5 years. In 1994 there were 20 children in each age class. Participants came from Covington, Atoka, Munsford (Tipton County) and Ripply (Lauderdale County). Services were provided from 6:15 a.m. to 5:00 p.m., with breakfast, lunch, and a snack provided by the center.<sup>20</sup>

The program centered on activities that provided structure, learning experiences, and enhanced cognitive skills. The 4 to 5 year olds were taught to write their name, address, telephone number, and other fundamental skills in preparation for kindergarten. There was a waiting list for the program. CCLC was the only program that required a fee (\$40.00 per year).

**After School Child Care.** This program began in 1989, the same year the Child Care Learning Center (ASCC) was implemented. The service population was largely from Covington, however. The program fell under the Pre-School Division in tandem with the pre-school program. The After School Child Care program targeted children ages of six to nine; however, eight children from the CCLC program (4 to 5 age class) also attended the program.<sup>21</sup> The children were read to, and, at times the older children read to the preschoolers. Students were encouraged to complete homework assignments as well. The majority of the children attending the program came from Covington Elementary, resulting from an effort to capture those children who would otherwise be “latch key” children of working parents.

**Group Involvement for Toddlers.** Group Involvement for Toddlers (GIFT) program was designed for children ages 3 to 4 years and their parents. Parents attended the program with their child in a group setting. Parents were provided instruction in parenting skills as the children are prepared for pre-school classes. In 1994 there were 6 clients in this program.

### **Department of Youth Services**

Youth Services, with 6 programs, was the largest department of the four. The department head was a new hire with only one month on the job, at the time of the site visit. She was a health educator with previous experience with middle school and high school students in rural Tennessee. In general, the age appropriate programs were designed to educate, socialize, and provide a safe haven where children were welcomed and encouraged to talk with peers and staff personnel about significant issues in a non-judgmental environment.

Some children actively sought help from the agency, “referring themselves” to programs. When the youths began a program, they filled out an entrance questionnaire. In general, “they are looking for help. They are looking for ways that they can either get along better with their families or ways they can . . . finish high school,” observed one department head. Another member of the staff commented that the children needed someone they could relate to, someone they could trust.

**Bright Futures Supportive Services.** Bright Futures Supportive Services (BFSS), introduced in 1988, was an ambitious program designed to continuously follow female participants from the time of their enrollment at age 12 until the participant graduated from high school. The major objectives of the program were to prevent teenage pregnancy and to encourage the completion of high school. The program facilitator noted that many of the girls entering the program were sexually active by the age of 13 and that it was not uncommon for adolescents of this age to have had a child. Underscoring this point, the program facilitator

pointed out that there were three pregnant 12 year olds currently enrolled in the agency's prenatal program.

The program's first class graduated high school in 1993—6 young women—none with a child. An additional seven were expected to graduate in 1994. If a participant becomes pregnant, she would automatically be transferred to the Maternal and Infant Health Outreach Workers program. Although the primary goal of the program was to prevent teen pregnancies, the program was successful in providing a wide range of support services to vulnerable adolescents and their families.

BFSS had two primary components, home visits and group sessions conducted at the agency's center. Once an individual was identified and enrolled in the program, a staff member would initiate a home visit to meet and discuss the goals of the program with the adolescent and her family, providing a base-line social assessment. Home visits were performed weekly for the first month and then once a month through the life of the program. Home visits allowed the staff to assess the family dynamics and encourage parental involvement.

The program staff who assisted the youth as facilitators were called "natural helpers," and functioned as mentors, confidants, and role models. Theoretically, they would follow the participants throughout the program, providing continuity. The natural helpers were women of the community who had been high risk youths themselves and understood the obstacles faced by adolescents (Bommer et al. 1993:5).

Group sessions took place on Saturdays at the center—initially occurring twice a month for the first eight months and then monthly. If transportation was necessary, the participants were transported to the center by agency vans. Program participants (there were 90 in the program in 1994) were divided into two groups which meet at the center on alternate Saturdays. Each group

was further divided into five subgroups, with each subgroup meeting with one of the five natural helpers. The sessions ran roughly five hours, from 9:00 a.m. to 2:00 p.m., with lunch served to the participants. Each session had a topic which was covered in-depth in both large and small group settings. Topics revolved around health issues that were designed to engage the participants in active discussion. Table 5-15 is a sample of topics covered by the program (Bommer 1993). In 1994 there were 90 adolescents enrolled in BFSS. In the previous year, there was funding for a total of 39 new participants. For the 1994 BFSS' budget cycle there was funding for only 15 new enrollees, which was a drastic decrease from the previous year.

**Enlightened Males.** The Enlightened Males (EM) program, introduced in 1990, was described by the agency's staff as a male counterpart to BFSS.<sup>22</sup> In addition to the goals and objectives of the BFSS program, the Enlightened Males program incorporated pronounced drug and violence prevention components into its design. The program targeted young men aged 10 to 17—children who, Bommer described as “kids [who] haven't done anything wrong. . . . What we try to do is to give these young men attention before there is a problem.”<sup>23</sup> In 1994, there were 20 youth in the program.

**Straight-Talk for Children/After-School Prevention Program.** Straight-Talk for Children/After-School Prevention, introduced in 1991, was described as an outreach program offering “group interaction, tutoring, educational information and activities in a structured, safe, non-threatening, non-judgmental environment” (Children & Family Services 1994:5). The target population was children (male and female) ages 6 to 17. In 1994 there were 30 children in the program. Participation was limited to six months.

**Second Chance.** The Second Chance program, introduced in 1992, targeted children ages 10 to 18 who had been identified to have discipline problems. Children were referred by parents,

school authorities, or through the judicial system. The director emphasized the youths were not repeat offenders, or “hardened juvenile delinquents,” and the intent of the program was to identify and rescue troubled children before it was too late. Second Chance was a six month time-limited program. In 1994 there were 21 children enrolled in the program.

**New Directions.** The New Directions program, introduced in 1992, targeted children ages 10 to 12 from single-parent families. The program’s primary foci were health education, conflict resolution, and social competency skills. This program also had a limit on the duration of participation. In 1994, there were 41 participants.

**Sisters’ Program.** The Sisters’ Program, introduced in 1992, targeted girls aged nine to eleven. The program was designed to reach preteens with the objective to “prevent adolescent problems.” In 1994 there were 20 participants.

### **Department of Community Services**

The Department of Community Services coordinated services for clients, encouraged parental participation, and engendered community support for the agency. Child parenting and child abuse prevention components were incorporated into all agency activities; even so, it was a critical focus of services provided by the department.

**Parent Involvement program.** The department administered the Parent Involvement program, introduced in 1991. Foci for this program included parenting skills, self esteem, self awareness, navigating the public school system, accessing community resources, training and counseling to upgrade job skills, and to obtain a GED or further education. One component of the program was the coordination of the Parent Board. The Parent Board consisted of two parents from each program who came together once a month to discuss issues relevant to the agency. The objective was to encourage community participation in the agency’s operation. In 1994 there were 26 members on the board.

**Additional program activities.** Socialization was a key process imbedded in all of Children and Family Services' programs and was fundamental to the agency's philosophy. Bommer said many of the agency children lacked basic socialization—the basic skills—to compete in the world at large. She attributed this to two fundamental factors (1) their parents were not socialized outside of their ethnic enclave, and (2) the restrictions of severe, endemic poverty. Case in point, she explained how, on a field trip to a movie theater in a neighboring county (there was no movie theater in Tipton County at the time) she realized the children “didn't know how to act.” To her surprise, they had never been to a movie theater before, so she had to “teach them the rules.” Still, it was not uncommon to find children new to the agency who had never visited a state park or been to Memphis just 38 miles to the south of Covington.

Throughout the year special events and activities were planned for the various program participants. The events provided what Minnie referred to as “socialization” and exposure to “life on the outside.” Activities included field trips to state parks, movies, skating, bowling, college campuses, for example. The youths frequently wrote and staged plays on various topics (e.g., driving drunk), especially during summer camp. The agency also organized fund raisers twice a year, a banquet in the fall and a Fun Festival in the summer, where the children are incorporated into the activities.

### **Agency Staff**

Children and Family Service's staff had grown as the agency matured—most were from the community and several had worked with the agency for a number of years. Some had professional degrees while others were trained on the job. Consultant professionals and committed volunteers augmented the staff. Professionals were brought in as needed to train staff, to develop educational/health materials and assessment tools, and to provide counseling. Some offered their services at reduced rates; some donated their services. Parents with children

engaged in agency programs were recruited to participate as volunteers. The agency also recruited women (volunteers) from the neighborhoods within the catchment area to assist in programs such as Bright Futures. In 1994 there were two Vista Volunteers participating in the program, along with community volunteers.

### **Funding Sources**

Children and Family Services' funding sources were diverse and included public funding sources at every level, federal, state, local; and private funding from numerous organizations and foundations (Table 5-16). Some funding was time-limited, while others were renewable from year to year. Most of the funding received was for specific programs or specific issues such as drug abuse prevention or smoking cessation. Monies for renovation and physical plant upkeep were far more difficult to obtain.

The executive director had expert knowledge of the state bureaucracy and the healthcare system, which gave her insight in securing funding sources. Even so, funding was a constant full-time job, in the director's opinion; and if she were unable to produce funding resources, the agency would not survive. At the time, she was training members of the staff in grant and proposal writing. She also envisioned that the board would take a more active role in fund raising.

In 1994, the Children and Family Services' annual budget was roughly \$500,000 a year, with an additional commitment of approximately \$50,000 in matching funds. Some of the matching funds were met with in-kind contributions. The agency produced two fund raising events annually, a banquet in the fall and a Fun Festival in the summer. Each event raised about \$500.

## **Barriers**

The executive director used innovative methods to overcome barriers and effectively made use of limited resources. However, barriers to care included funding, available physical space, accessible and affordable health care, and community perceptions—including institutional racism.

## **Funding**

As described above, the agency depended on funding sources that were, for the most part, transitory requiring perpetual searching to develop new (or renew) resources to sustain the agency. Funding for expanding and maintaining the physical buildings had been particularly difficult to obtain, limiting programs and the number of participants served. In other words, there were far more potential clients than Children and Family Services could accommodate; there were 328 single-female families and 1,224 children living in poverty in the city of Covington alone—and within the catchment area there were over 2,000 single-female families and 9,000 children living in poverty—the majority of whom were black (U.S. Census Bureau 1993b).<sup>24</sup>

## **Community Perceptions and Institutionalized Racism**

Patterns of institutionalized racism remained in this area of Tennessee and were reinforced within the wider social structure. For example, the mayor was a member of the Sons of Confederates and organized other members to participate in public celebratory events. During such events, members would dress in Civil War uniforms, fly the Confederate flag, and fire cannons in tribute to an era when blacks were subjugated property of white Confederates. For some blacks these events were seen as a public display to reinforce white supremacy, reminding blacks *and* the community that white males were still their master. After a Memorial Day parade, the director wrote a letter to the local newspaper expressing her opinion that the Civil

War was “a war of division” and that to publicly fly the Confederate flag was hurtful to the black population. Her letter was met with angry letters, but the Confederate flag is no longer displayed in the Memorial Day parade.

Institutionalized racism actually fueled the genesis of the agency (see Agency History above), and these same patterns, remained the most difficult to overcome. Children and Family Services struggled to survive, with little community support. Dominated by whites, throughout the catchment area there was a vacuum of social services for blacks. Some community leaders perceived Children and Family Services as “just a little social service agency,” according to the director, and—although she has been recognized for her unflagging community service by community leaders—town elders continued to fail to validate the successes of Children and Family Services. More specifically, one county commissioner had repeatedly opposed the agency’s development on numerous occasions, including trying to block funding for the Second Chance program.

### **Access to Primary Health Care**

Tipton County did not have access to a federally funded community health center such as s in the previous or following case studies, leaving the medical care for the uninsured to the generosity of local private physicians. Agency personnel repeatedly cited the need for accessible and affordable primary health care at the agency as well as for the wider population, in spite of the fact that there were four black physicians (MDs) practicing in Tipton County—two internists, one OB/GYN, and one family practitioner. According to the director, most physicians in Tipton County were reluctant to treat Medicaid patients due to the low reimbursement rate for services, a situation that had worsened with the advent of TennCare in January 1994. Underscoring this point, one-fourth (25.8 %) of the population in Tipton County received healthcare under TennCare (1994), and all of the counties in the catchment area were designated as physician

shortage areas for primary care (HRSA 2005).<sup>25</sup> In a community survey prepared by Children and Family Services (1992-1993), people were asked what types of additional programs the community would like the agency to provide. “Health clinic” was at the top of the list. Thus, in her clinical judgment, the director considered establishing a primary healthcare clinic as a critical need for the agency.

### **Evaluation**

A community evaluation of Children and Family Services was conducted annually based on a survey distributed to clients, schools, and physicians’ offices. The survey was constructed of open and close ended questions that broadly focused on the agency and its programs. In the 1992-1993 evaluation, 124 survey questionnaires were completed, and, of those respondents, over 90% (112) had some level of knowledge of the agency and the majority (77.4 %) responded they thought Children and Family Services was “well run and organized.”

On an internal level, the director used video as an evaluation tool. All special events and program events were video recorded and used to evaluate staff and activities. The videos also served as instructional tools for clients and staff.

### **Addendum 2008**

Children and Family Services continues to provide services to the four counties with the addition of Shelby County. The agency remains a nonprofit entity providing services to low-income families. Youth and children programs continue to be important to the philosophy of the agency. The Enrichment and Intervention Services program, Children and Family Services inaugural program, continues to provide services to infants to children of the age of three.

National political and economic forces have validated the founding director’s vision of providing services to the most vulnerable children of the county. Children and Family Services’ Enrichment and Intervention program has been replicated, in part, at the state level through a

program called Tennessee's Early Intervention System. The state program became a reality through the federal passage of Public Law 108-446, Individuals with Disabilities Education Improvement Act of 2004. One of the intended goals of this historic legislation is "to assist States in the implementation of a statewide, comprehensive, coordinated, multidisciplinary, interagency, system of early intervention services for infants and toddlers with disabilities and their families" (Public Law 108-446, Part D, Section 651).

The black adolescent birth rate in Tipton County has declined significantly since 1994 (Tennessee Department of Health 2007). At the time of the site visit (1992-1994 three year average) the rate was 35.3 per 1,000 women (age 10-17), and for the years 2004-2006 the rate had declined to 16.6 per 1,000 women (age 10-17). Tipton County's overall black birth rate had declined even further than the state black rate (15.6 versus 16.7 per 1,000 women respectively). Black infant mortality has also improved, falling from 24.8 per 1,000 live births (1994-1996 three year average) to 18.1 per 1,000 live births for the time period of 2004-2006.

Table 5-1. Total population, percent black, percent white, and percent rural, 1990: United States, Tennessee, Children and Family Services catchment area counties.

	Total population	Sq miles	Density <sup>a</sup>	Black %	White %	Rural %
U.S.	248,709,438	3,537,438.0	70.3	12.0	80.3	24.8
TN	4,877,185	41,219.5	118.3	15.9	83.0	39.1
Fayette	25,559	704.5	36.3	44.2	55.5	100.0
<b>Haywood<sup>b</sup></b>	<b>19,437</b>	<b>533.2</b>	<b>36.5</b>	<b>49.5</b>	<b>49.7</b>	<b>48.5</b>
<b>Lauderdale</b>	<b>23,491</b>	<b>470.5</b>	<b>49.9</b>	<b>31.2</b>	<b>68.2</b>	<b>73.7</b>
Tipton	37,568	459.4	81.8	23.5	75.5	80.1

Source: *1990 Census of the Population, Social and Economic Characteristics: Tennessee*, U.S. Bureau 1993d. (Note: <sup>a</sup>Density is the population per square mile. <sup>b</sup>Areas in bold are persistent poverty counties.)

Table 5-2. Percentage of population in poverty, 1990: United States, Tennessee, and Children and Family Services.

	Total population %	White %	Black %
U.S.	13.1	9.8	29.5
TN	15.7	12.5	32.4
Fayette	24.1	14.1	37.0
<b>Haywood</b>	<b>27.5</b>	<b>15.5</b>	<b>39.0</b>
<b>Lauderdale</b>	<b>22.4</b>	<b>16.2</b>	<b>37.2</b>
Tipton	20.0	12.3	45.3
Covington City	37.0	17.4	64.5

Sources: U.S. Census Bureau (1993a:3,6,7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993b:9-10, 39-40, 43-44) *1990 Census of Population, Social and Economic Characteristics, Tennessee*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold are persistent poverty counties.)

Table 5-3. Per capita incomes, 1990: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	\$14,420	\$15,687	\$8,859
TN	\$12,255	\$13,201	\$7,859
Fayette	\$9,627	\$12,986	\$5,435
<b>Haywood</b>	<b>\$8,695</b>	<b>\$8,695</b>	<b>\$5,787</b>
<b>Lauderdale</b>	<b>\$8,607</b>	<b>\$10,101</b>	<b>\$5,397</b>
Tipton	\$9,796	\$11,072	\$5,397
Covington City	\$8,812	\$11,299	\$4,263

Sources: U.S. Census Bureau (1993a: 3, 6, 7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993b: 9-10, 39-40, 43-44) *1990 Census of Population, Social and Economic Characteristics, Tennessee*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold are persistent poverty counties.)

Table 5-4. Unemployment rates, 1990: United States, Tennessee, Children and Family Services catchment area.

	Total population %	White %	Black%
U.S.	6.3	5.2	12.9
TN	6.4	5.4	12.3
Fayette	8.4	4.7	14.3
<b>Haywood</b>	<b>8.7</b>	<b>5.3</b>	<b>12.9</b>
<b>Lauderdale</b>	<b>11.0</b>	<b>8.0</b>	<b>19.5</b>
Tipton	7.7	5.6	16.1
Covington City	10.9	5.9	21.5

Sources: U.S. Census Bureau (1993a:2, 7, 9) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993b:5-6, 39-40, 43-44) *1990 Census of Population, Social and Economic Characteristics, Tennessee*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold are persistent poverty counties.)

Table 5-5. Educational attainment as a percentage of the population 25 years or older with a high school education or higher, 1990: United States, Tennessee, and Children and Family Services.

	Total population %	White %	Black %
U.S.	75.2	77.9	63.1
TN	68.2	70.0	59.4
Fayette	55.8	66.8	37.7
<b>Haywood</b>	<b>53.0</b>	<b>59.8</b>	<b>45.0</b>
<b>Lauderdale</b>	<b>52.1</b>	<b>55.3</b>	<b>43.5</b>
Tipton	61.8	66.0	44.5
Covington City	53.3	59.5	39.9

Sources: U.S. Census Bureau (1993a:1, 6, 7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993b:39-40, 43-44) *1990 Census of Population, Social and Economic Characteristics, Tennessee*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold are persistent poverty counties.)

Table 5-6. Mortality rates for all causes, age-adjusted per 100,000, three year averages for the years 1992-1994: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	914.9	886.6	1,220.7
TN	997.1	955.9	1,285.1
Fayette	984.0	931.4	1,058.9
<b>Haywood</b>	<b>1,078.4</b>	<b>1,027.6</b>	<b>1,153.8</b>
<b>Lauderdale</b>	<b>1,177.5</b>	<b>1,147.4</b>	<b>1,244.2</b>
Tipton	1,030.0	1,007.9	1,145.1

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Note: Areas in bold are persistent poverty counties.)

Table 5-7. Heart disease mortality rates, age-adjusted per 100,000, three year averages for the years 1992-1994: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	303.2	298.3	373.4
TN	326.2	316.7	400.3
Fayette	291.1	276.6	312.6
<b>Haywood</b>	<b>399.6</b>	<b>402.9</b>	<b>393.8</b>
<b>Lauderdale</b>	<b>436.5</b>	<b>427.2</b>	<b>457.6</b>
Tipton	330.5	352.9	278.8

Source: Centers for Disease Control and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Note: Areas in bold are persistent poverty counties.)

Table 5-8. Cancer mortality rates, age-adjusted per 100,000, three year averages for the years 1992-1994: United States, Tennessee, and Children & Family Services catchment area.

	Total population	White	Black
U.S.	215.9	211.9	277.0
TN	223.7	214.9	293.3
Fayette	215.3	203.6	232.5
<b>Haywood</b>	<b>246.3</b>	<b>243.3</b>	<b>249.9</b>
<b>Lauderdale</b>	<b>253.5</b>	<b>239.2</b>	<b>293.2</b>
Tipton	244.5	236.7	282.9

Source: Centers for Disease Control and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Note: Areas in bold are persistent poverty counties.)

Table 5-9. Cerebrovascular disease mortality rates, age-adjusted per 100,000, three year averages for the years 1992-1994: United States, Tennessee, and Children & Family Services.

	Total population	White	Black
U.S.	62.4	60.1	85.9
TN	80.4	76.5	110.2
Fayette	125.7	136.4	113.1
<b>Haywood<sup>a</sup></b>	<b>68.8</b>	<b>39.2<sup>b</sup></b>	<b>110.2</b>
<b>Lauderdale</b>	<b>90.1</b>	<b>88.9</b>	<b>95.1</b>
Tipton	72.1	67.3	94.9

Source: Centers for Disease Control and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes. <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> CDC reported this rate as unreliable due to less than 20 deaths in the three year time period.)

Table 5-10. Suicide mortality rates, age-adjusted per 100,000, three year averages for the years 1992-1994: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	12.0	12.8	7.0
TN	12.8	13.7	7.2
Fayette	5.4 <sup>b</sup>	1.8 <sup>b</sup>	11.2 <sup>b</sup>
<b>Haywood<sup>a</sup></b>	<b>12.3<sup>b</sup></b>	<b>19.9<sup>b</sup></b>	<b>3.2<sup>b</sup></b>
<b>Lauderdale</b>	<b>11.0<sup>b</sup></b>	<b>16.1<sup>b</sup></b>	<b>No data reported</b>
Tipton	13.4 <sup>b</sup>	15.1 <sup>b</sup>	7.8 <sup>b</sup>

Source: Centers for Disease Control and Prevention, CDC Wonder on-line database, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes. <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> CDC reported this rate as unreliable due to less than 20 deaths in the three year time period.)

Table 5-11. Infant mortality rates per 1,000 live births, three year averages for the years 1992-1994: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	8.3	6.8	16.3
TN	9.3	6.7	17.8
Fayette	13.2 <sup>b</sup>	6.8 <sup>b</sup>	20.1 <sup>b</sup>
<b>Haywood<sup>a</sup></b>	<b>13.9<sup>b</sup></b>	<b>16.0<sup>b</sup></b>	<b>12.6<sup>b</sup></b>
<b>Lauderdale</b>	<b>9.0<sup>b</sup></b>	<b>4.4<sup>b</sup></b>	<b>16.8<sup>b</sup></b>
Tipton	14.8	10.3 <sup>b</sup>	24.8 <sup>b</sup>

Source: Centers for Disease Control and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed June 2005. (Notes. <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> CDC reported this rate as unreliable due to less than 20 deaths in the three year time period.)

Table 5-12. Crude birth rates per 1,000 women of child bearing age, three year averages for the years 1992-1994: United States, Tennessee, and Children and Family Services catchment area.

	Total population	White	Black
U.S.	15.4	14.6	20.1
TN	14.2	13.0	20.5
Fayette	15.0	13.3	17.4
<b>Haywood</b>	<b>15.9</b>	<b>12.8</b>	<b>18.9</b>
<b>Lauderdale</b>	<b>14.9</b>	<b>13.6</b>	<b>17.5</b>
Tipton	15.9	14.3	21.9

Sources: Brady, E. Hamilton, Paul Sutton, and Stephanie Ventura, 2003:13, Revised Birth and Fertility Rates for the 1990s and New Rates for Hispanic Populations, 2000 and 2001: United States. Table1. Number of births, crude birth rates, general fertility rates, and birth rates by age and race of mother: United States, 1990-2001 (revised June 2004). National Vital Statistic Reports 51(12):1-96. Electronic document, [http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51\\_12.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_12.pdf), accessed March 2008; Tennessee Department of Health, Health Information Tennessee, electronic document, <http://hit.state.tn.us/>, accessed October 2007. (Note: Areas in bold are persistent poverty counties.)

Table 5-13. Adolescent pregnancy rates, crude birth rate per females ages 10 to 17, three year averages for the years 1992-1994: Children and Family Services' catchment area.

	Total Population	White	Black
TN	17.1	12.4	35.3
Fayette	15.0	15.3	31.7
<b>Haywood</b>	<b>15.9</b>	<b>14.8</b>	<b>39.6</b>
<b>Lauderdale</b>	<b>25.9</b>	<b>21.7</b>	<b>33.5</b>
Tipton	20.1	13.9	36.7

Source: Tennessee Department of Health, Health Information Tennessee, electronic document, <http://hit.state.tn.us/>, accessed October 2007. (Note: Areas in bold are persistent poverty counties.)

Table 5-14. Selected 1990 poverty characteristics for blacks in the Children & Family Services catchment area.

	Black families living in poverty <sup>a</sup>	Children under 18 years living in poverty
Covington city	41.0%	1,010
Fayette	29.8%	1,647
<b>Haywood<sup>b</sup></b>	<b>37.3%</b>	<b>1,499</b>
<b>Lauderdale</b>	<b>34.6%</b>	<b>1,019</b>
Tipton	39.7%	1,887

Source: U.S. Census Bureau (1993b:417,419,421,425,705) *1990 Census of Population, Social and Economic Characteristics, Tennessee*. Washington, D.C.:U.S. Department of Commerce. (Notes: <sup>a</sup>The denominator for black families living in poverty is the total number of black families. <sup>b</sup>Areas in bold are persistent poverty counties.)

Table 5-15. Bright Futures: group session topics.

Alcohol & drugs	Problem solving
Anatomy	Self discipline
Aids	Self esteem
Black history	Sexual abuse
Contraceptives	Sexually transmitted diseases
Decision making	Skin care
Hygiene	Smoking
Peer pressure	Stress management
Pregnancy	

Table 5-16. Illustration of Children and Family Services funding sources

<b>Private Funding</b>	<b>Public Funding</b>
Ford Foundation	Covington Housing Authority
Greater Memphis Foundation	Federal Block Grant Monies
Kaiser Family Foundation	TN Black Health Care Task Force
Robert Woods Johnson	TN Commission on Children and Youth
Save the Children	TN Dept of Employment Security
United Way of Greater Memphis	TN Dept of Education
Van Leer Foundation (Netherlands)	TN Dept of Health
	TN Dept of Mental Health

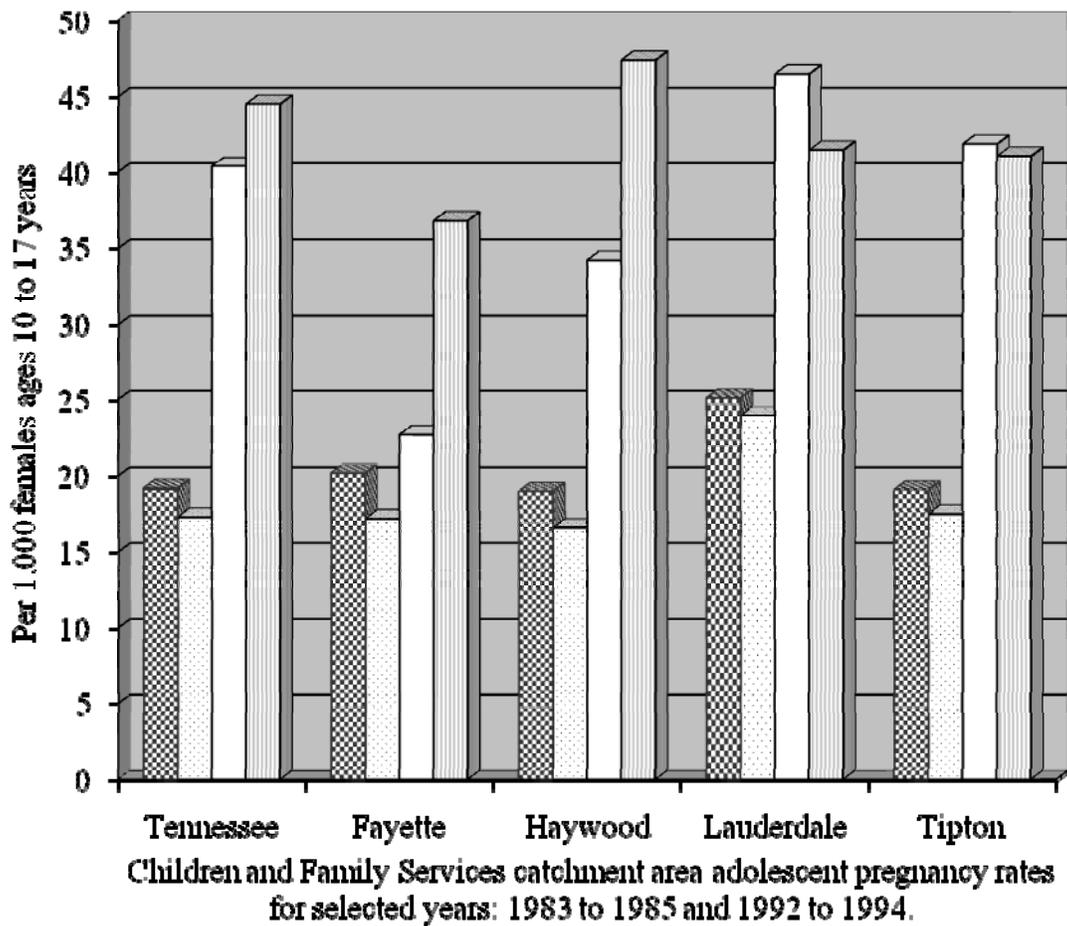


Figure 5-1. Comparison of adolescent pregnancy rates from the inception of Children and Family Services and the time of the field site research. (Source: Tennessee Department of Health, Health Information Tennessee (HIT). Electronic database, <http://hit.state.tn.us>.)

## Notes

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<sup>1</sup> Although the counties' economic designations are manufacturing, agriculture remains an important factor in Tennessee's agricultural economy. In 1990, all four counties were ranked in the top ten for cotton and soybean production. Haywood was ranked number one in the state for cotton production, Tipton was ranked 3<sup>rd</sup>, and Fayette was ranked 4<sup>th</sup> (Tennessee Department of Agriculture no date).

<sup>2</sup> In the state and the catchment area, other minorities account for less than one percent of the population.

<sup>3</sup> Heart disease mortality rates were based on ICD-9 codes 390-398, 402, 402-429, per 100,000 of the population and are age-adjusted using year 2000 population. The rates are three year averages for the years 1992-1994.

<sup>4</sup> Cancer rates were based on ICD-9 codes 140-239, age-adjusted per 100,000 using year 2000 population. The rates are three year averages for the years 1992-1994.

<sup>5</sup> Cerebrovascular mortality rates were based on ICD-9 430-438 codes, per 100,000 population of the population and are age-adjusted using year 2000 population. The rates are three year averages for the years 1992-1994.

<sup>6</sup> Suicide mortality rates were based on ICD-9 codes 950-959, per 100,000 of the population and are age-adjusted using year 2000 population. The rates are three year averages for the years 1992-994.

<sup>7</sup> Infant mortality rates are derived from the CDC Wonder database. They are crude birth rates based on 1,000 live births. All rates are the year averages for the years 1992-1994.

<sup>8</sup> Birth rates are derived from the Tennessee Department of Health, HIT database, electronic database, <http://hit.state.tn.us/BithRate/>, accessed October 2007. All rates are per 1,000 women, and are three year averages for the years 1992-1994.

<sup>9</sup> Children and Family Services' first program began services in the summer of 1985.

<sup>10</sup> All adolescent fertility rates are from the Tennessee Department of Health, Health Information Tennessee (HIT) electronic database <http://hit.state.tn.us/birth.aspx>. Tennessee Department of Health defines adolescents as females ages 10 to 17.

<sup>11</sup> All four counties were designated as Medically Underserved Areas (MUA) since 1978 (HRSA 2005).

<sup>12</sup> For this discussion, health care resources are measured by presence of hospital and the number of licensed beds, federally funded community health center (clinic), primary care physicians, pediatricians, OB/GYN physicians, psychiatric specialists (defined as psychiatrists, child psychiatrists, psychoanalysts, & psychosomatic specialists), and dentists—based on 1994 Manpower data and 1994 hospital data as cited in Tennessee's Health: Picture of the Present, Part II 1994.

<sup>13</sup> The 1990 aggregate poverty levels for the four counties were: Fayette 24.1%, Haywood 27.5%, Lauderdale 22.4%, Tipton 20% (U.S. Census Bureau 1993: 313-319).

<sup>14</sup> In my research I could not verify the total number of disabled children. The U.S. Census Bureau counts disability, but reports persons 16 years and older. For Covington, persons reported a disability with mobility or self-care limitation N = 604, accounting for 11.8% of the population age 16 and older N = 5,126 (U.S. Census Bureau 1993:620).

<sup>15</sup> The organization was originally named Tri-County Children and Family Services. In 1991, the name was changed to Children and Family Services and services were extended to Haywood County.

<sup>16</sup> At the time of the site visit, Minnie was no longer an Alderman.

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<sup>17</sup> The “Agency” refers to the community in the singular, which for the most part is the reference area of Covington, but the catchment area for some of the agency’s many programs are extended to the border counties of Fayette, Haywood, and Lauderdale, as well as capturing populations beyond Covington, but within Tipton County.

<sup>18</sup> The Agency transported children with Agency vans to the physicians’ offices for vision and dental screenings. The services donated by the practitioners were then counted as “in-kind” monies, which could be listed as “matching funds” that the Agency had to meet in accordance with some funding agencies. In 1994, the Agency was required to match \$50,000 in cash and in-kind.

<sup>19</sup> Handicapped was defined as “a diagnosis of suspected or established developmental disability, which cause the child to function at a retarded level, a diagnosis of suspected or established developmental delay or a child at high risk for delay” (unpublished manuscript). By 1994, the services were reduced to children ranging in ages from birth to three.

<sup>20</sup> Children and Family Services maintained a fully equipped kitchen with a staff of one to manage it.

<sup>21</sup> There were other after school programs for different age groups, but After School Child Care was distinct from them (e.g., Straight Talk for Children/After School Prevention).

<sup>22</sup> The Enlightened Males program is briefly described, as are a number of the Agency’s programs, due to the limited information we received on the program.

<sup>23</sup> The drug prevention and violence components of Enlighten Males, was most likely funded by the state health department based on health surveillance data. The importance of these components should be noted: in 1996 homicide was (1) the leading cause of death for blacks ages 15 through 34; the second leading cause of death for black children ages 5-14; and (3) the third for infants and toddlers 1-4 years old.

<sup>24</sup> The category I refer to as single-female families is the U.S. Census Bureau category defined as “Female householder, no husband present, with related children under 18 years” (U.S. Census Bureau 1993).

<sup>25</sup> Percentage of the population enrolled in TennCare in the other three counties within the catchment area was similarly high: Fayette 27%, Haywood 35.6%, Lauderdale 35.2%. On another note, three of the four counties, Fayette, Haywood, and Lauderdale were physician shortage areas for obstetrics as well. The Tipton County Health Department administrator stated there were three OB/GYN doctors who accept Medicaid patients.

## CHAPTER 6 WEST ALABAMA HEALTH SERVICES

### **Introduction**

West Alabama Health Services was an innovative nonprofit agency providing health care to a sizeable area, nearly 5,000 square miles, in west Alabama. The agency administered a network of Federally Qualified Community Health Centers, with administrative offices and the primary community health center, the E. A. Maddox Community Health Center, located in Eutaw, the county seat of Greene County.

Located in the heart of the Deep South in western Alabama, contemporary Greene County encompasses 646 square miles (U.S. Census Bureau 2001c:18), with an unusual topology. Spatially, Greene County is 15 miles southeast of Tuscaloosa and 45 miles southeast of Birmingham, with its western boundary at one point within approximately 15 miles of the Mississippi River. Three of Greene County's boundaries are formed naturally by three rivers: the Tombigbee, the Black Warrior, and the Sipsey, a geographical point of significance in the county's history (Eutaw Area Chamber of Commerce nd; Greene County Historical Society 1991).

Today, Greene County takes pride in its surviving Ante-Bellum homes, echoes from the past of wealth and cotton plantations (Greene County Historical Society 1991; Lancaster 1979). The survival of these historical buildings, there were 24 placed on the historical record in 1991, was a direct result of the county's isolation imposed by the three rivers (Greene County Historical Society 1991). As the Civil War was coming to an end, Sherman and his men marched southward into the very heart of Confederacy land. Tuscaloosa, just to the north of Greene County, was scavenged and burned to rubble by Union Forces, while Greene County's bridges were destroyed to thwart a Union invasion (Greene County Historical Society 1991:1).

A confluence of historical forces has left deep furrows on Greene County. Greene County was established in 1819, at a time when Alabama remained a Territory (Lancaster 1979:18). Immensely large, covering some of the richest agricultural lands, the county thrived on agriculture. The surviving Ante-Bellum homes—marking Greene County’s distant affluence—remain as a reminder of a time past when cotton was the economic engine of the region, powered by black slave labor.

For over a century, cotton was the major agricultural focus for Greene County.<sup>1</sup> Architectural historian Clay Lancaster describes Greene County as, “the heart of Cotton Kingdom” (Lancaster 1979:18).<sup>2</sup> The Black Warrior River, which at the time ran through Greene County, was accessible by steam boats, providing transportation of baled cotton from Greene County to Mobile. One narrative from the first U.S. Census described Mobile as one of the largest cotton market in the United States second only to New Orleans (Mitchell 1846:64-65).

As a territory, Alabama had institutionalized the practice of slavery to support their agricultural economy. With its accession to the United States in 1840, the former territory brought with it nearly half a million people—43% of whom were slaves—and a booming agricultural spirit with a third of the population engaged in agriculture (Mitchell 1846:64-65). In contrast to the state proportion of slaves in 1840, Greene County’s slave population was significantly higher, 68.4%. By the end of the decade, Greene County’s slave population had swelled to 76.5% (U.S. Census Bureau 1872a:11-12).

This significant rise in slaves in Greene County reflected the intensity of agriculture. More specifically, from 1850 through the Civil War, cotton production spiked to historical levels. Prior to the Civil War Greene County produced 25,680 bales of ginned cotton in the year 1850,

the highest production for the county at that time, and was ranked fifth in the state for cotton production (U.S. Census Bureau 1854:196-199). By the year 1860, production of ginned cotton more than doubled—57,858 bales—the zenith of cotton production for Greene County (U.S. Census Bureau 1864b:2-3). After the War, cotton production dropped, rallied in the latter years of the century, and then slowly diminished through the twentieth century (U.S. Census Bureau 1872b:96; 1884:4; 1895:393; 1908:30; 1910:35; 1924:83; 1942:331; 1952:105; 1975:65; 1994b:336).

Returning to the agricultural production in Greene County in 1850, there were over a thousand farms in Greene County and the county was the number one state producer in the following categories: horses, asses, and mules; sheep, corn, and wool. Greene County ranked second for cattle, swine, potatoes, hops, and clover production; third for wheat, butter and cheese, and maple sugar; fourth for rye and oats, beeswax and honey (U.S. Census Bureau 1854:196-199).

The U.S. Census for Greene County from 1860 to 1870 reflected a radical drop in the county's population and cotton production. The county's population fell from 30,859 to 18,399 and cotton production fell from 57,858 to 9,910 bales (U.S. Census Bureau 1864a:8; U.S. Census Bureau 1872a:11; U.S. Census Bureau 1864b:3; U.S. Census Bureau 1872b:96). These statistics appear to be the aftershocks of the war. On the contrary, Greene County had been halved in 1867 to create another county; acreage east of the Black Warrior River created Hale County (Lancaster 1979:18). Hale was the larger of the two counties and with the acreage, Hale also took with it much of the agricultural production (U.S. Census Bureau 1872b). Hale County, in 1870, produced nearly twice the amount of cotton as did Greene County—18,573 versus 9,910 bales.<sup>3</sup>

By 1992, Greene County's population was just over 10,000, 80.6% black, and agricultural production was nearly stagnant. The majority of the productive farms were controlled, as it was in 1850, by white farmers even though blacks remained in the majority (U.S. Census Bureau 1992c:15; 1994c:166, 435). As a point of reference, blacks owned 16.5% of the farms, controlling less than four percent of the farm acreage in Greene County (U.S. Census Bureau 1994c:166, 435).<sup>4</sup> The total number of farms had fallen to 255, and half recorded net losses. The remaining agricultural products recorded for the county (1992) were horses and ponies, cattle, corn for feed, soybeans, and hay and alfalfa, a shadow of the county's previous prosperity. Vegetables and cotton were negligible commodities—less than ten percent of the acres farmed supported harvested crops. Cotton production had fallen to 659 bales, with 405 acres cultivated under seven farms (U.S. Census 1994c:401).<sup>5</sup> Five years later there was only one cotton farm with no documented production (USDA 1999c:402). Green County had lost its place in the economic cotton market and had become an incongruent contrast of beautiful Antebellum homes and poverty.

Returning to the successful health program, the E. A. Maddox Community Health Center was the first community health center administered by West Alabama Health Services. The agency over time added additional health services and five satellite clinics in the surrounding counties of Choctaw, Hale, Marengo, Lowndes, and Sumter. In total, the six counties represented a catchment area covering nearly five thousand square miles. Extreme poverty exemplified the catchment area—all six counties were designated as persistent poverty counties by the federal government (USDA). Hale County was a distal toe to the Appalachian Mountains and officially designated as an Appalachian county (Appalachian Regional Commission 2007).

Greene County was surrounded by endemic poverty, and the depth of poverty in the catchment area for blacks was shocking. The poverty level for blacks, who dominated Greene County, was four times higher than the U.S. (general) population. The low poverty level for whites in Greene County was in sharp contrast to black poverty, 7.6% to 54.7%, or, from a different perspective, blacks endured a rate of poverty over seven times that of their white co-residents.

For contextual comparison purposes, demographic, sociodemographic, and health profiles of the six counties will follow. Some counties fared better than others on certain socioeconomic and health indicators. However, without exception, blacks fared worse than the white population throughout the catchment area. Although the catchment area is defined, the focus of this study is limited to the West Alabama Health Services, an agency that has transformed health care in Eutaw and the surrounding counties.

### **Sociodemographic and Socioeconomic Indicators**

#### **Selected Catchment Area Sociodemographic Indicators, 1990**

The sociodemographic characteristics (see, Table 6-1) define the catchment area as mainly black and rural. Blacks were numerically predominate in most counties, with the exception of Choctaw and Hale where there was relative parity. Greene County had the largest proportion (80.6 %) of blacks, and Lowndes ranked second with 74.6%. Choctaw County had the lowest percentage of blacks, 44.2%, but still well above the state and national rates.

Three of the counties, Choctaw, Greene, and Lowndes, were designated as 100% rural. The remaining counties ranged from 80 to 56% rural. The population density for all counties is extremely low compared to Alabama (79.6 persons per square mile) and U.S. (70.3 persons per square mile), as one may expect given their rural status. The three counties designated as 100% rural also had the lowest population densities. Greene County had the lowest population density

(15.7 persons per square mile) and Hale had the highest (24.1 persons per square mile) within the catchment area.

Of the six counties, Greene County was the smallest county with the fewest people, 100% rural, and experienced the largest population of blacks in the catchment area. A large portion (36.9 %) of the black population in Greene County was under the age of 18 years, and a significant number (21.7 %) of the white population were over 65 years.

### **Selected Catchment Area Socioeconomic Indicators, 1990: Poverty Rates, Per Capita Income, Unemployment Rates, and Educational Attainment**

The catchment area, compared to national rates exhibited extreme poverty, low per capita incomes, low educational attainment, and high unemployment rates. Compared to Alabama, the catchment area fared far worse than other Alabamians except for one sociodemographic indicator: unemployment. The unemployment rate for Hale County equaled the state rate of 6.9%, but remained higher than the national rate (6.3 %). Sociodemographic indicators demonstrated a wide disparity between whites and blacks.

#### **Poverty**

The national poverty level of 13.1% obscures the stark difference between whites and blacks. The national poverty level for blacks was three times higher than the rate for whites (see, Table 6-2). The Alabama poverty rate was considerably higher than the national level, with both white and black poverty levels higher than the national rates. Nearly 40% of the black population in Alabama lived in poverty—more than three times higher than their white co-residents. Within the catchment area, poverty for blacks was more acute, and without exception, higher than the state level. All of the catchment area counties demonstrated poverty rates of nearly 50%—ranging from 48.4% in Choctaw to 54.7% in Greene County. From another perspective, blacks

in Lowndes County had a poverty rate of nearly nine times higher than whites. In Greene County, blacks had a poverty rate over seven times higher than the white rate.

Whites in the catchment area fared exceptionally well in contrast to blacks. Half of the counties reflected poverty levels lower than the national white poverty level of 9.8%: 5.6%, Lowndes; 7.6%, Greene; and 9.7%, Marengo.<sup>6</sup> From one perspective, the poverty levels in Greene County appear incongruent. The aggregate poverty level was the highest of all counties, while the white poverty level (7.6 %) was considerably lower than the national rate, reflecting Greene County's relatively affluent white population.

### **Per capita income**

The per capita income for blacks, as with poverty, exhibited disparities with aggregate incomes at all geopolitical levels (see, Table 6-3). Although the national aggregate income was \$14,420, the comparable black per capita income was \$8,859; at the state level it was \$6,473; and at the county level the incomes were even more depressed for all counties ranging from \$6,291 in Choctaw to \$4,153 in Lowndes County.<sup>7</sup> For blacks the per capita income at the state level was nearly \$8,000 lower than the national aggregate rate. From the national level to the catchment area counties, the income gap among blacks ranged from \$8,129 (Choctaw) to \$10,269 (Lowndes) lower than the national aggregate average. In Greene County, the income gap between blacks and the national aggregate per capita income was \$9,783.

Comparisons drawn from white per capita incomes to black incomes at the various geopolitical levels reveal startling differences between whites and blacks. The national per capita income for blacks was \$6,828 lower than the national per capita level for whites. The income gap difference between blacks Alabamians to white Alabamians population was \$6,762, slightly less than at the national level. At the county level, income gap differences were as low

as \$5,973 (Choctaw) and as high as \$12,057 (Marengo) between whites and blacks. In Greene County the income difference between whites and blacks was \$8,628.

### **Unemployment rate**

Unemployment rates in the catchment area counties were mixed. Comparing the aggregate population's unemployment rates, all of the rates were higher than the national average (Table 6-4). Comparing white unemployment rates, Alabama and all counties, except one (Choctaw), had lower unemployment rates than whites at the national level. Unemployment rates among whites in the Greene and Hale Counties were three times lower than the national average. Blacks in Choctaw County, by comparison, had an unemployment rate over 2.5 times greater than the national average.

White versus black unemployment rates reveals a similar pattern: the black population at all geopolitical levels had higher rates than did whites. Blacks in Greene County had an unemployment rate over six times higher than their white co-residents. In Hale and Marengo County the unemployment gap, was five times higher than whites. The highest unemployment was found in Choctaw (18%), and the lowest rate was found in Hale County (11.1 %).

### **Educational attainment**

The national rate of educational attainment for the U.S. was 75.2% (Table 6-5). Whites were better educated than blacks, at all geopolitical levels, demonstrating a distinct educational gap between the white and black populations. At the national level, white educational attainment was 77.9% versus 63.1% for blacks. At the state level the educational attainment was lower than the national rate. White educational attainment in Alabama was considerably lower than whites at the national level. Just over half (54.6 %) of the blacks in Alabama held a high school diploma.

The counties in the catchment area exhibited a disparaging gap between whites and black educational attainment, although most whites in the catchment area had a higher educational attainment level than the state level. Interestingly, whites in Sumter County achieved the highest educational attainment in the catchment area, yet blacks had the lowest educational attainment. Blacks in Greene County had the highest black educational attainment (47.6 %) in the catchment area. Even so, blacks in Greene County were far less educated than blacks at the state and national level.

### **Selected Catchment Area Health Outcomes, 1992-1994: An Ethnoepidemiological Surveillance**

#### **Mortality Rate, All Causes**

The mortality rates for all causes demonstrate that Alabama's rates for whites and blacks were somewhat higher compared to U.S. mortality rates (Table 6-6).<sup>8</sup> The Alabama black mortality rate was essentially equal (0.1 % higher) to blacks at the national level, while white Alabamians' mortality rate was 6.9% higher than whites at national level white. However, when white and black Alabamians are compared to one another, blacks fared far worse than their white co-residents. The difference was substantial: the black mortality rate for all causes was 28.9% higher than the white mortality rate statewide.

**Black mortality rates.** Mortality rates for blacks in the catchment area when compared to their black counterparts at the national and state level were mixed. Three counties had lower rates than the national and state rates, and three counties had higher rates. The lowest black mortality rate was found in Sumter County, 11.7% lower than the national rate for blacks and 11.8% lower than the state rate. The highest black mortality rate was found in Hale County, 4.9% higher than the national rate and 4.8% higher than the state rate.

Comparison between the catchment area black mortality rates to the national aggregate population rates reveals a more pronounced difference. The highest mortality rate (for blacks in Hale County) was 40.0% higher than the national aggregate rate. The lowest black mortality rate (in Sumter County) was 17.9 higher than the national aggregate rate.

**White mortality rates.** White Alabamians had a higher mortality rate than whites at the national level. Within the catchment area the mortality rates for the white populations were mixed, two counties (Lowndes and Sumter) had lower rates than whites at the national level, and four counties (Choctaw, Hale, Lowndes, and Sumter) had lower rates than whites at the state level. Sumter County had the lowest rate, 9.7% lower than the national white level, and 15.6% lower than the state white rate. Conversely, Marengo County had the highest white mortality rate 10.1% higher than the national white rate, and three percent higher than the state white rate.

**Greene County mortality rates.** The mortality rate for the total population of Greene County was higher than the national and the state mortality rates. Surprisingly, blacks in Greene County had a relatively low mortality rate—lower than the state and national black rate, while whites in Greene County had the second highest mortality rate among the catchment counties—a rate higher than both the state and the national white rate. This suggests that the local health care system was effective in lowering the mortality rates for blacks in Greene County. Overall, though, the white population mortality rates were significantly lower than those of blacks in Greene County even though the whites did not seem to be benefiting from the local health care resources to the same degree as the blacks.

### **Heart Disease Mortality Rates**

Death due to heart disease in Alabama was higher than the national average (Table 6-7).<sup>9</sup> Comparing white and black Alabamians to their respective national counterparts, a differing pattern emerges. Whites in Alabama had a slightly higher heart disease mortality rate than

whites at the national level, but black Alabamians' rate was slightly lower than the national black rate. Nevertheless, black Alabamians had a 15.4% higher health disease mortality rate than their white counterparts.

**Black heart disease mortality rates.** Within the catchment area, three counties (Choctaw, Marengo, and Sumter) had heart disease mortality rates lower than the national rate, and two counties (Marengo and Sumter) had lower rates than the state rate. Sumter County had the lowest rate in the catchment area, 24.7% lower than the national black rate and 21.4% lower than the state black rate. Lowndes County's blacks had an exceptionally high heart disease mortality rate, 40.3% higher than the national black rate and 41.5% higher than the state black rate. In Sumter and Choctaw Counties, the white and black mortality rates were similar between the two respective populations, but in the other four counties the black rates varied from 20.4% to 53.2% higher than the respective white populations.

**White heart disease mortality rate.** Within the catchment area, two counties (Marengo and Sumter) had lower heart disease mortality rates than the national and state white rates. Marengo County had the lowest white mortality rate for heart disease, 10.6% lower than the national white rate and 16.8% lower than the state white rate. The highest heart disease mortality rate among whites was found in Greene County, 30.4% higher than the national white rate and 21.3% higher than the state rate.

**Greene County heart disease mortality rates.** The heart disease mortality rate for the aggregate population of Greene County was the second highest rate in the catchment area and much higher than the national and state rates. Whites in Greene County, as stated above, had the highest heart disease mortality rate among the white populations of the catchment area counties, and much higher than the state or national rates for the white populations. Blacks in Greene

County had the third highest mortality rate among the black populations of the catchment counties, and, also, much above the state and national rates for the black populations. When compared to each other, the black population fared much worse than the white population of Greene County. Greene County fared poorly for both races.

### **Cancer Mortality Rates**

Comparing U.S. cancer mortality rates to Alabama we find a similar pattern as with heart disease mortality rates.<sup>10</sup> Alabamians had a higher death rate due to cancer than the general population (Table 6-8). However, white Alabamians had a slightly higher mortality rate 0.6% than the U.S. white rate, and black Alabamians had a slightly lower rate 1.9% than the national black rate.

**Black cancer mortality rates.** Black cancer mortality rates within the catchment area were generally lower than the national and state black rates. Four out of the six counties had lower rates. The lowest cancer rate was in Lowndes County, 17.5% lower than the national rate and 16.0% lower than the state rate. The highest cancer mortality rate was in Choctaw County, 7.1% higher than the national black rate and 9.1% higher than the state black rate.

**White cancer mortality rates.** Cancer mortality rates for whites in the catchment area were lower than the national and state white rates, with the exception of Marengo County. Marengo County's cancer rate was 7.3% higher than the national white rate and 6.7% higher than the state white rate. Sumter County had the lowest cancer rate, 14.9% lower than the national white rate and 15.4% lower than the state white rate.

**Greene County cancer mortality rates.** Greene County (aggregate population) had the third lowest cancer rate in the catchment area, but remained higher than the national or state rate. The cancer rate for whites in Greene County was the third lowest in the catchment area and was

lower than the national and state white rates. The cancer rate for blacks in Greene County was the third highest in the catchment area, slightly below the mean for the group.<sup>11</sup>

### **Cerebrovascular Mortality Rates**

In the aggregate, Alabama's cerebrovascular mortality rate was 10.6% higher than the national aggregate rate (Table 6-9).<sup>12</sup> The cerebrovascular disease mortality rates by ethnicity for much of the catchment area were reported as unreliable due to death counts were lower than 20, making an analysis of the data problematic. Only in Hale and Marengo Counties for whites and blacks, and in Sumter County for blacks, were the numbers of deaths high enough to be considered reliable. At the county level, aggregate rates were reliable. Marengo and Hale Counties had the highest death rates due to cerebrovascular disease. In Marengo County, where the rate was the highest, the aggregate cerebrovascular mortality rate was 95.5% higher than the national rate. In Marengo County the cerebrovascular rate for blacks was 185.7% higher than the national aggregate rate. Hale County had the highest white cerebrovascular disease rate, more than double the national average. Here in Hale County the cerebrovascular mortality rate for blacks was also high compared to the national aggregate rate but was somewhat lower than the comparable white population. Although the white and black cerebrovascular disease mortality rates were largely unreliable in the other four counties, the general trend suggests the white rate was substantially higher than the black rate.

### **Suicide Mortality Rate**

Alabama's suicide rate, for the aggregate population, was only slightly higher than the U.S. rate (Table 6-10).<sup>13</sup> At both the national level and the state level, the white suicide rates were considerably higher than the black suicide mortality rates. Due to the small number of deaths due to suicide recorded for the three year period in the catchment area, an analysis of the catchment area is not possible.<sup>14</sup>

## **Infant Mortality Rates**

Alabama had the third highest infant mortality rate in the United States for the years 1992 to 1994.<sup>15</sup> Compared to the general population, the Alabama infant mortality rate was higher by 24.1% (Table 6-11). Infant mortality rates present a more distinctive picture when the data are disaggregated by race.<sup>16</sup> At the national level, the black infant mortality rate was more than double the rate for white infants. The death rate for white infants in Alabama was slightly higher than the national average for white infants, but for black Alabama infants the death rate was slightly lower than the national average for black infants. The black rate was more than double the white infant mortality rate in Alabama.

An analysis at the catchment area level is problematic due to the low number of infant deaths for the three year period. For white infants in the six counties the number of deaths ranged from one in Sumter County to no deaths in Greene County. Black infant deaths ranged from a high of 16 in Sumter County to a low of five in Lowndes County. Greene County had seven black infant deaths for the years 1992 to 1994. Although the individual county level data are not reliable, the general trend at the county level seems consistent with the differences between black and white infant mortality at the state and national levels, with higher incidents of infant mortality among black infants than among white infants.

## **Agency History**

The creation of West Alabama Health Services in 1974 and implementation of the E. A. Maddox Community Health Center in 1975 was borne out of the tumultuous 1960s. The 1960s was a time when the national conscience was awakened by President Johnson's idealism of a Great Society. Pressing national issues such as poverty, racial inequities, inadequate housing, hunger, and restricted access to health care by the poor and minorities were the subjects of much

debate in Washington as well as across the country. President Johnson established task forces aimed at ameliorating such conditions (Litman and Roberts 1997:129).<sup>17</sup>

As a result, federal monies from a variety of federal agencies became available at the local level for communities to develop needed services to improve the lives of the poor and underserved. Those funds were to go directly to community leaders who could demonstrate the skills and plans to implement such programs. Theoretically, such demonstration projects worked through the spirit of community action projects: grassroots participation, innovative visions, leadership, and, above all, as a collaborative process. In the South, action did not always follow theory.

### **The Great Society, Civil Rights, and the Birth of a Clinic**

The cultural context of western Alabama at that point in time was one of heightened racial tensions. Western Alabama was at the epicenter of the Civil Rights movement, where blacks endured physical, economic, and psychological violence from their white co-residents as a matter of white propriety and entitlement. Little changed in western Alabama after the Civil Rights laws were enacted by Congress (United States Commission on Civil Rights 1983). In fact, many blacks in western Alabama faced further repression and reprisals, as whites attempted to maintain the status quo through resistance, intimidation, and, in some cases, blatant denial of the basic human rights of blacks. It was a time when white county residents removed their children from public schools and placed them in private academies in an attempt to nullify school desegregation, often leaving the public schools with little funding for textbooks and repairs to the physical plant. Tactics of intimidation were used to block blacks from registering to vote for example, there were reports of black farmers in fear of losing their lands after registering to vote, with banks suddenly questioning farm loans, and some tenant farmers in Sumter County were summarily forced off the land after registering to vote (Bethell 1982:4,6). Any organizational

attempts on the part of blacks were met with suspicion and, in some cases, with fierce opposition (see the case of the Federation of Southern Cooperatives' briefly described below).

Blatant white opposition to the Civil Rights laws in Alabama was validated through the political actions of white officials from county governance to the state house. One of the most illuminating examples of such support comes from then Alabama governor, George Wallace, when, in 1968, his political platform included a promised to “repeal of all civil rights laws and the usage of bayonets to enforce the restoration of segregation” (Bethell 1982:7). While Alabamian whites had the support of the governor, blacks—with the assistance of the federal government—had the power to organize.

### **Southwest Alabama Farmers Cooperative**

The Southwest Alabama Farmers Cooperative Association (organized in 1966), a black farming cooperative, was one of the first community organizations to garner federal monies in the pursuit of improvement in the lives of blacks in western Alabama. The co-op, serving a ten county catchment area, proved successful in its first year of operation. Its success drew controversy and criticism from nearly its inception. White citizens and state politicians organized to have its funding revoked by the Office of Economic Opportunity.<sup>18</sup> A group of concerned citizens, later joined by the governor of Alabama (Lurleen Wallace), flew to Washington to directly confront the director of the Office of Economic Opportunity complaining the Office was “subsidizing a bunch of would be revolutionaries” (Bethell 1982:6). The white delegation from Alabama firmly believed members of the Southwest Alabama Farmers Cooperative Association were “a bunch of uppity blacks . . . using federal OEO money to overturn the economic status quo of southwest Alabama” (Bethell 1982:6).

## **Federation of Southern Cooperatives versus West Alabama Health Services.**

By 1969, the Southwest Alabama Farmers Cooperative Association joined with 21 other cooperatives in the creation of a new umbrella organization to serve the needs of the fledgling cooperatives. The new organization was the Federation of Southern Cooperatives, and eventually based its training headquarters in Sumter County. This cooperative went beyond farming issues—albeit farming was its centerpiece—and helped to establish health clinics, credit unions, and other programs to improve the status of blacks across the Black Belt of Alabama. It was the Federation of Southern Cooperatives that originally applied for grant money to establish the first community health center in the state of Alabama (Bethell 1982).<sup>19</sup>

**Conflict or politics.** Federation of Southern Cooperatives' application to establish a health care center in Sumter County was immediately and effectively blocked, possibly over the political skirmish with Southwest Alabama Farmers Cooperative, or the racial undertones of the time. In any regard, an Alabama Congressman and the Alabama State Health Planning Agency effectively blocked the Federation of Southern Cooperative's application pointing out to the granting agency that the proposed board of directors was composed entirely of blacks, and thus not representative of the catchment area demographics.

## **Greene County Competes for Grant Monies**

Community leaders in Greene County, sensing the issue as a racial dilemma—and supported by the Greene County Commission—formed a competing governing Board creating West Alabama Health Services, Inc.<sup>20</sup> The current executive director of West Alabama Health Services was then a member of the Greene County government (an elected official) and a high school principal. He “walked in to write [the] grant” application for a health clinic. As he recalled, there were “problems in Sumter,” motivating Greene County to seek federal funding for a health clinic.

The U.S. Public Health Service, after receiving Grant applications from Southern Farms Cooperative and West Alabama Health Services in neighboring counties, requested the two agencies collaborate for the grant. “The two organizations attempted several times to make [a] joint application for the funds but were turned down, until finally, West Alabama Health Services was awarded the grant in 1974 on the basis of its integrated board” (American Hospital Association 1993:10).

**Resistance from within and without.** Within a very short time, resistance for the project mounted at the local and state level. The West Alabama Health Services’ executive director said “the federal government is not well liked in this area. . . . don’t like social medicine. . . . don’t like mid-levels” [practitioners e.g., nurse practitioners]. He was referring to the general community and the medical community. The white community was deeply suspicious of anything linked to the federal government. Hadn’t the federal government interceded in matters giving blacks rights? The medical community, there were four private physicians in the area, perceived the proposed health clinic as in direct competition with their economic interests—usurping their medical knowledge—putting them out of business. The American Medical Association (AMA) organized and joined forces with the state of Alabama. The state perceived the federal government was encroaching in state governance (state’s rights). The state and the AMA filed a lawsuit to eliminate all U.S. Public Health Service health clinics, a suit that they did not win. It was within this climate that West Alabama Health Services opened the doors of the E. A. Maddox Community Health Center in 1975.

### **Recognition of a Problem**

Community leaders in Greene County, a medically underserved community, had long recognized a need for access to health care in their community. In 1970, 82% of the black population in Greene County was living in poverty. The highest level of poverty found in a 16

county region. As few as 10.8% held a high school diploma, and most had no formal linkages to health care, nor knew how to establish them. As a result, many blacks relied on medicine passed from one generation to the next (U.S. Commission on Civil Rights 1983:8,12,51).

Physicians in the county provided little care to the black community, a setting that led to substandard care for blacks. The area hospital and public health department was not designed nor equipped to provide comprehensive health care to such a large indigent population. In 1970 there were over 8,000 blacks representing approximately 75.4% of Greene County's population, most living in poverty [U.S. Census Bureau 1975:4]).

### **Barriers to care**

There were a number of barriers to providing access to health care within the larger catchment area, as there were in Greene County. Barriers included (1) distrust of authoritative people, including whites; (2) lack of transportation; (3) poor communication—many did not own a telephone; (4) low health knowledge; and of course (5) extreme poverty. One staff member recalled that it was difficult to engage the rural population in participating within the health services at the clinic. Some elders in the more isolated communities continued to use folk medicine, trusting time honored health practices passed down through the generations rather than the more scientific evidence-based medicine.

### **Critical health care issues**

Some of the most pressing health issues for the catchment area included, as detailed above, heart disease, stroke, and high infant mortality rates.<sup>21</sup> The catchment population, in addition, suffered disproportionately from hypertension, diabetes, teen pregnancy, substance abuse, and obesity due to a sedentary lifestyle. One doctor explained that 50% of her patients presented with diabetes, leading to a cascade of secondary health issues. Health care for AIDS patients was also part of the fabric of the community as young natives returned from the cities to be cared

for by family members. One physician described it as the “coming home syndrome . . . where AIDS patients come home to die. Of the pregnancies followed by West Alabama Health Services staff, approximately 30% were high-risk in need of additional care. West Alabama Health Services, knowing the challenges before them, planned and operated one of the most innovative community health centers in the South.

### **Agency Description**

This case study is the most complex of the three, and the following is a gross overview of the agency. By 1994, West Alabama Health Services had evolved into a massive organization, somewhat resembling a bureaucratic institution, with numerous programs, subsidiary companies, and an intricate network of formal and informal agreements that spanned both private and public institutions from the national to the local level. The agency was engaged also in numerous collaborative coalitions involving major institutions, other companies, hospitals, health centers, state, and local and city governments to name a few. The agency also administered a vast number of programs.

During the two day site visit, we were given a broad overview of West Alabama Health Services, but little substantive information.<sup>22</sup> During the site visit, we deviated little from our facilitator’s preplanned schedule.<sup>23</sup> Generally, we were ushered from one interview to the next. Interviews were relatively short and limited to a few prominent employees—mostly from the higher echelon of the agency—and a few program directors.<sup>24</sup> We had asked to visit some of the satellite clinics, participate in outreach or home visits, but were discouraged due to time limitations. We did have an opportunity to visit one of the school clinics and attend an interdisciplinary meeting.

The key interviews produced only general information about the agency. In most cases respondents repetitiously provided only gross overviews of the agency and key programs, while

program directors sketched out their program in the broadest of terms, or simply mentioned they existed. In some instances we were provided copies of program manuals or other materials for a better understanding. All of the previewed programs, like the agency, were prominent, large-scale, multifaceted undertakings. Therefore, in addition to the data gathered at the site, some secondary data was used for clarity.

### **Philosophical Pragmatism**

From the agency's inception, the majority of the West Alabama Health Services governing body, as long standing members of the community, possessed an innate comprehension of the needs of the community. The founders were acutely aware that providing access to medical services through a community clinic would not be sufficient by itself to improve the health of their community, and their mission was to improve the health of blacks. To realize this fundamental goal, the founders had to address the very culture of the black community, for, within the catchment area, isolated groups of blacks essentially represented separate disenfranchised ethnic enclaves. Providing services to the disenfranchised was the agency's immediate challenge. In response, the agency adopted a philosophical pragmatism.

West Alabama Health Services, by 1994, had grown immensely providing comprehensive medical care to communities across western Alabama.<sup>25</sup> In 1994, West Alabama Health Services employed approximately 250 employees with an operational budget over five million dollars. In the main clinic alone, the providers would see approximately 100 patients a day. How did a small rural health clinic in one of the most impoverished areas in the country successfully provide comprehensive medical care to their clients? One practitioner said "through the hard work of a lot of people. . . . many wearing five hats."

As the agency quickly grew, its administrators: sought to and hire a variety of talented interdisciplinary personnel; developed collaborative agreements to expand the scope of care;

made a commitment to grant writing, research, and data collection, and produced programs aimed at education, prevention, and intervention. Outside of the realm of health per se, innovative youth programs sought to engage the youth among the population to prevent school dropout, dangerous behavior, teen pregnancy, and most of all to give them guidance to ensure a choice for a bright future. All of these endeavors combined to produce more than a community health center. The agency had evolved into an intricate health care delivery system and more, providing a holistic approach to improve the catchment area's health through interactive collaboration and community involvement.

### **Personnel**

From the very beginning, the agency took a pragmatic approach to recruitment. The fledgling agency realized two important considerations: the need for culturally appropriate providers, and the need for specialized talent to run the agency. Most of the clinical practitioners and employees in 1994 were black, some of whom were native to the catchment area, a few were from Greene County.

The leaders of West Alabama Health Services provided clinical services from a broad interdisciplinary approach, involving health professionals at all levels. The cadre of employees included physicians, physician's assistants, nurse practitioners, dentists, nutritionists, administrators, and project managers, outreach workers, with diverse degrees and expertise in health administration, public health, business administration, education, gerontology, social work, health education, community development, grant writing, computer science, and research.<sup>26</sup> Each employee was handpicked for their unique skills, which were evaluated on how the individual skills would strengthen the agency.

## **Collaboration and cooperation**

Collaboration and cooperation was a core principle of West Alabama Health Services. It was an essential and basic element in surviving in a hostile environment. Some of segments of the community opposed what they perceived as special treatment accorded to the black population. Others did not trust the agency and did not perceive its utility. Limited local resources necessitated increasing cooperation and collaboration with outside entities. Below is a brief outline of some of the most prominent forms of collaboration and cooperation.

## **Transportation**

The administrator and his staff were quick to detect that transportation was a serious problem for the target population. Few blacks had reliable transportation. As the administrator recalled, there was one elderly patient who was on dialysis. For his dialysis treatment he had to travel several times a week to Birmingham. He owned a car with serious reliability issues, which finally was not repairable. The elderly gentleman was unable to afford to replace the vehicle, leaving him in a dilemma. His case was the catalyst for West Alabama Health Services to develop a transportation system.

Working with another county program that had a limited local community transportation project, West Alabama Health Services sought grants to establish a broader system that covered the entire catchment area. They started with two vans in 1976 and had a fleet of 250 by 1994. The vans were a shared resource with West Alabama Health Services' patients and clients. The vans crisscrossed the state of Alabama, according to one source, with frequent trips to Birmingham, Montgomery, and Tuscaloosa. The vans were also used for getting to and from work, to the grocery store, or whatever the needs of the community. Youths participating in West Alabama Health Services' youth programs were also provided with transportation. The

transportation system was one of the most important factors of providing health care to the catchment area.

Community members of West Alabama Health Services had, from the beginning, operated in the manner of action anthropology, in collaboration with all strata of the community. One key respondent explained that academic research in the rural setting is very different from that in the academic setting: “research is done with the community’s input and advice throughout the planning to implementation stages—community trust is imperative in carrying out the research. . . . Research projects have to be collaborative efforts in which the community benefits from the results.”

This respondent’s perception was biased toward academic research, but the theme of community support, trust, and cooperation ran through most of the narratives. The first step to providing health care to the rural (isolated) populations began with a cultural sensitivity approach and engaging as many people as possible. Assessing the needs of the community necessitated constant cooperation and collaboration with the target population and continued through interactive programs and services, such as the Planned Approach to Community Health program and the Teen Involvement Program (see below).

## **Hospitals**

On a more formal level, the agency entered into collaborative agreements as a way of expanding resources. As an example, West Alabama Health Services developed a hospital consortium to expand inpatient care to cover the catchment area. West Alabama Health Services was the lead agency for the West Alabama Rural Health Consortium, a hospital based rural health care program funded by the Robert Wood Johnson Foundation.<sup>27</sup> The consortium consisted of ten hospitals and agencies, a program of collaboration covering eleven counties.<sup>28</sup> The goals of the program were multifaceted: “(1) provide shared specialty/professional services;

(2) promote marketing and public relations; (3) improve the quality and expertise of personnel; (4) increase the integration of services; and (5) develop administrative and managerial systems”

(West Alabama Health Services, nd). Examples include:

- Contractual agreements for referral were developed to provide enhanced clinical services between five rural hospitals and the Druid City Hospital and Regional Medical Center (DCH Regional Medical Center, an urban hospital in Tuscaloosa); and
- The director of the consortium (an employee of West Alabama Health Services) routinely meet with consortium members, in particular with hospital administrators, to discuss, plan, and implement common projects (American Hospital Association 1993:11).
- The University of Alabama’s School of Medicine (Tuscaloosa) also was a member of the consortium bringing to the program a full array of resources including technical expertise and manpower.

### **Clinical Practitioners**

Similarly, West Alabama Health Services developed a consortium to attract and retain health care professionals within rural Alabama.<sup>29</sup> Formally referred to as the Rural Alabama Health Professional Training Consortium (RAHPTC), the agency collaborated with a number of universities to provide training experiences for students in medical and health care fields such as, medicine (medical students, interns, residents), public health, nursing, dentistry, nutrition, optometry, social work, and more recently, hospital and health administration. Participating academic institutions included University of Alabama, the University of Alabama at Birmingham, Samford University, University of Alabama at Huntsville, Auburn University, University of Morehouse University School of Medicine (Atlanta), and the University of South Alabama (Mobile). Students rotated through West Alabama Health Services from six weeks to five months. The consortium had facilitated approximately 108 students since 1990.<sup>30</sup> The collaboration provided an active and successful recruitment tool for West Alabama Health Services, and, in turn, West Alabama Health Services provided exceptional training sites for academic institutions to provide their students with experience in rural health.<sup>31</sup>

Collaboration and cooperation began as a necessity and developed into a vast network where, in some cases reluctant, entities banded together to bring the best possible health care to western Alabama. Much of the formal collaborative agreements were predicated on funding, funding the agency cultivated through a variety of grants from the federal, state, and local level, and through a variety of private foundations. In other words, West Alabama Health Services facilitated linkages through funding sources not readily available to other community entities.

### **Funding**

Funding was the economic engine of West Alabama Health Services. Funding for West Alabama Health Services programs originated from local, state, federal, and private sources. As stated above, the federal government provided funding for the first and subsequent community health centers, in support of primary health care though the community leaders knew the community needs were far greater than access to a clinic.<sup>32</sup> The solution to address the many needs came in the form of a cyclical pattern of research, data collection, grant writing, additional programs, and then more research, etc.

**Grant writing and research.** The agency by 1994 had acquired a professional grant writer who understood the nuances and necessity of grant writing. He was a Professor of Medicine recruited from the University of Alabama's School of Medicine where he had worked in academia for about 25 years. He explained that "programmatically grants are shepherded" by the agency. In his expert opinion, West Alabama Health Services' programs not only helped people, but also generated data, which assisted in generating more grant monies. West Alabama Health Services had developed many such programs over time, too numerous to review at this time. However, in addition to the few mentioned above, a few salient programs will be presented below.

## **Programs**

### **Planned approach to community health (PATCH)**

The agency participated in Centers for Disease Control and Prevention's pilot program in the early eighties for the Planned Approach to Community Health program. The Planned Approach to Community Health was a tool used to evaluate community health needs and, with this knowledge, to plan and implement health education programs (see, for example, Kreuter 1992). The program was designed as a collaborative effort between CDC (funding and technical assistance), the Alabama Health Department, West Alabama Health Services, and community leaders.

The PATCH program, as administered by West Alabama Health Services, focused on the large minority population residing within West Alabama Health Services' catchment area and included three major components: (1) community mobilization, (2) community diagnoses, and (3) community interventions. Community mobilization relied on trust between West Alabama Health Services and the more isolated black communities. This community strategy was the beginning of a protracted process of engendering a relationship of trust between West Alabama Health Services and hard to reach black populations within the catchment area. The medical director of West Alabama Health Services was a key to the process of trust building, and one of the most influential persons in the community. She was a community member, living, and working in Greene County for nearly two decades, providing primary health care, as well as obstetrical, and gynecological services to the indigents of the county.<sup>33</sup> It was with her leadership the program was instituted.

The second component of the PATCH program, community diagnoses, identified the community's needs through data collection, opinion survey, and CDC's Behavioral Risk Factor Survey (BRFSS). We were not given specifics of what needs were identified through this

process, but nonetheless, this component identified issues which required intervention. What is known is the agency researchers identified hypertension as a major health issue in the area. West Alabama Health Services' key physician reported that out of 1,000 persons studied in Sumter, Greene, and Hale Communities, 560 were found to be hypertensive. Findings of this nature warranted intervention, which is the final stage of the PATCH program.

The third component of the PATCH program is the planning, design, and implementation of programs to address the findings. Programs gave priority to health education (including health prevention and health promotion), clinical intervention, and monitoring through follow-up and outreach if necessary. In the case of the hypertension findings, WASH attracted funding from for a hypertension study which provided lifelong medication for its participants, in conjunction with ongoing health education and exercise interventions.<sup>34</sup>

### **Teen Involvement Program**

West Alabama Health Services had recently developed innovative programs designed to engage the youth of west Alabama in life enrichment skills. According to the director of programs 90% of school dropouts occurred before the ninth grade. While there was no program targeting the very youngest children, the agency had developed a sophisticated complex of activities targeting youth between the ages of nine to nineteen within the counties of Greene, Hale, Marengo, and Sumter.

The program was called the Teen Involvement Program. The program was multifaceted with many components. Anyone within the age parameters was encouraged to join. There were over 300 participants in 12 sites in four counties: Sumter, Greene, Hale, and Marengo. The program director estimated the program captured only ten percent of the area teens. He found in the early implementation stage that girls were the majority of the members, so he organized a pee-wee football team, and 70 boys joined the program. Since then, other sports have been

introduced into the program for example, baseball and basketball. The program was designed as an interactive experience involving adults and youth. There were many activities and components within the program, many of which were complete programs in themselves. A selected few Teen Involvement Programs are described briefly below.

**Teen clinic.** A major component of Teen Involvement Program was the Teen Clinic. The Teen Involvement Program offered a broad range of activities including competitive sports, dances, field trips, health education, and mentoring. To access the activities for example, play basketball or go to a dance, the teens had to have a “Teen Clinic” card. This card established that the youths had received a physical exam from one of the West Alabama Health Services’ health centers and all immunizations were current. The cards established the Teens were card carrying “Teen Clinic” members. Respondents who discussed the program often used the titles Teen Involvement Program and Teen Clinic interchangeably.

**Chess.** Community elders were sought to participate in the program as volunteers. For example, a number of the male black elders in the community were identified as expert chess players. They were recruited to mentor and teach youth how to play the game. It had been a very successful cooperative venture. The week after the site visit there was to be a regional chess tournament at the Eutaw town square.

**Drug summit.** The weekend before the site visit, the program manager had organized a Drug Summit. The summit brought together teens and their parents, over five hundred, with people from the district attorney’s office, sheriff’s office, judges, lawyers, and probation officers, to name a few. The purpose of the summit was to educate youth on the prosecution, legal ramifications of drug activity. The summit was a success, according the program manager. He was in the process of writing an article on the event for the local newspaper, *The Democrat*.

**Youth credit union.** Teen Involvement Program included a teen credit union, Big Wishes Youth Credit Union. The credit union was owned and operated by the youths with adult “coordinators.” This component of the program was structured to teach the youth the following: leadership skills, the principles of saving, how to budget, accounting skills, the role of a bank teller, prepare a financial statement, develop rules and policies of loaning money, operate a business, marketing skills, and public relation skills. The youth officers and their coordinators had recently attended a teen credit union conference in Washington, D.C.

**Sex education.** Teen Involvement Program provided other venues to provide health education and mentoring. The program had classes with revolving topics. Sexuality was one of the topics discussed because there was limited information provided by the public schools.<sup>35</sup> The program philosophy regarding sex emphasized “responsibility” and “safe sex,” as well as abstinence for the youth. Adolescent women were encouraged to delay pregnancy until they had completed their education. They were encouraged to wait until they had completed college, or at least until they were older and could more effectively deal with parenthood. The program director explained,

if you work with the kids and show them they can have a future that can include college, the kids will choose the responsibility of not having a child before they get their education. The key is to give the kids the nurturing and roots and show them that they do have options in life. They need to know that [they] do have options for their future. Early parenthood diminishes their options.

The program director also reflected that in the last two years there had been only two pregnancies, a very encouraging sign considering the high teen pregnancy rate in the area.

**Field trips.** The Teen Involvement Program also provided field trips to widen their view of the world, and to introduce them to tangible options they could achieve. The Teen Credit Union’s trip to the nation’s capital for a teen credit union conference, as mentioned above, is but one example. The youths routinely traveled to Birmingham, where they would meet with

academics, professionals, and businessmen, and tour campuses. Participants of the Teen Involvement Program were highly encouraged to consider medical tracks in any area of health.

### **Health Career Opportunity Program**

Health Career Opportunity Program is similar to the Teen Involvement Program, in that nurturing is a strong component of the program. The program was designed to identify junior and senior students who were interested in careers in primary health care at all levels. Interested students were screened by ACT scores, interviews, and in consultation with their principles and families. Out of approximately seven hundred students 25 were chosen for the program. Similar to the Teen Involvement Program, students toured universities, colleges, and medical centers to experience firsthand the work of medical professionals. Students were prepped on how to access financial aid, scholarships, and how to prepare an application.

The “Saturday Academy” was a valuable component of the program.<sup>36</sup> It provided the students with a structured and nurturing environment where students could track in a medical field of their interest. Community and professional mentors provided a specialized curriculum with a focus on mathematics and science. Tutoring was available for every student.

The program’s primary goal was an investment in the future of West Alabama Health Services—to encourage students to seek degrees in medicine and health, and then to return to the community to serve. The essence of program was to ensure the success of the students. The program was a new project therefore there was no outcome data.

### **Additional innovative programs**

The agency included other forward-looking programs to achieve health care linkages more distance, hard to reach community members. Health clinics were established in community churches and in the public schools. Community churches were approached by agency members to gain their trust and support in instituting mini-clinics within their organizations. Parishioners

were referred to one of the community health centers if needed. This linkage with the churches also provided sites to encourage lifestyle changes. For example, walking clubs were formed in churches to combat obesity co-linked variable for hypertension (the average weight for females in the community was approximately two hundred pounds). By one report, the clinics were well received by the community, and were another portal to the community. School clinics were also instituted in the public schools. None of the public schools, prior to West Alabama Health Services school project, had a clinic. A nurse practitioner oversaw the clinics, which were usually staffed with community health workers.

### **Barriers to Care**

West Alabama Health Services had managed to surmount most of the barriers to care faced when they opened their doors in 1975. A number of staff members spoke of “racial pressures.” The agency had recently purchased a house adjacent to the clinic. The house was listed on the historical register, but had not been renovated or lived in for a number of years. Once the agency attempted to purchase the property, the historical society objected. The historical society “went to court to block the clinic from owning it.” Once the house was purchased, the city refused to allow permits for the agency to make renovations. Ultimately, West Alabama did renovate the structure (Figure 6-1). However, at the time of the site visit, this was an ongoing issue.

West Alabama Health Services’ innovative programs and philosophical approach engendered by its collaboration, consortiums, cooperation, and community interactions was emulated across the nation. The agency was considered very successful by the Alabama Health Department, the Bureau of Primary Health Care, and the Office of Rural Health Policy in Washington, D.C. Both state and federal agencies collaborated, as they did in the beginning, with the agency expanding services to the community. West Alabama Health Services had, as one member said, “a visionary” staff.

## **Addendum 2008**

West Alabama Health Services is no longer in existence. Coincidentally, while I was an intern at the Office of Rural Health Policy in the summer of 2001, HRSA withdrew all federal funding for the agency's CHCs, amid allegations of malfeasance and fraud—and a Federal Bureau of Investigation (FBI) investigation into criminal activities was conducted in the name of the agency. The Director of the Office of Rural Health Policy—along with the Governor of Alabama and an Alabama United States congressman—flew to West Alabama in August of 2001 on a fact-finding mission to identify other health care resources to replace the vacuum created by the sudden closure of WAHS.<sup>37</sup> It is not clear if the allegations were substantiated.

By the year 2001, the agency encompassed 19 community health centers covering 17 counties in western and north central Alabama. The budget for the year 2000 was nearly 12 billion dollars (HRSA FOIA document). It had become the largest not-for-profit health care organization in the state (Savage et al. 2004:383, 392). West Alabama Health Services had become “omnipotent,” according to one informant, with its name “everywhere.” The CEO and medical director were touted as “national experts in rural health care” (Velasco 2001). The agency had become a powerful and influential social institution, with strong political ties at the local, state, and national level. West Alabama Health Services had become HRSA's jewel-in-the-crown CHC.

### **Acquisition of Family Healthcare Corporation**

In 1997 WAHS merged with Family Healthcare Corporation. West Alabama Health Services “acquired the business, property, and assets of Family Healthcare Corporation. . . . accomplished for and in the consideration of WAHS's assumption of Family Healthcare Corporation's debts and liabilities as set forth at the time of the acquisition” (Management Assistance Corporation 2001:1).<sup>38</sup> Family Healthcare Corporation—based in Tuscaloosa—was a

community health organization, similar to WAHS, providing primary health care through a network of six CHCs serving primarily impoverished white populations in Tuscaloosa and the “hill country” in nine counties. Prior to the purchase, WASH operated 13 clinics in eight counties (Savage et al. 2004:391-392). After acquiring Family Healthcare Corporation, the new entity was renamed Family Healthcare of Alabama to reflect the additional non-western counties.

It is important to note that HRSA and the Bureau of Primary Health Care continued to identify the newly created agency as West Alabama Health Services—grant applications continued to be submitted under the name of WAHS, and subsequent HRSA notice of grant awards were issued to West Alabama Health Services, Inc. HRSA, in formal communication, secondarily listed “d/b/a Family HealthCare of Alabama,” where d/b/a stands for “doing business as” (HRSA FOIA documents). Internally the agency also continued to identify itself as WAHS, as did the state and its former community service areas (Hayden 2001; Management Assistance Corporation 2001; DeWitt 2001c, 2001d, 2001g, 2001h, 2001i; Savage et al. 2004; Velasco 2002a, b).

At the time of the merger of the two entities, WAHS experienced a dramatic decrease in revenue for services rendered for maternal health care. In a letter to HRSA, dated February 5, 1999 (HRSA FIOA document), the CEO outlined the seemingly arbitrary cancellation of the Alabama Maternity Waiver Program administrated by the state Medicaid agency at the end of 1996. The state Maternity Waiver Program contracted with one local organization in each county to provide perinatal care, including case management, at a 97% of the fee-for-service reimbursement (Wiener et al. 1998: 32). The program which had been awarded to WAHS for six consecutive years since its inception in 1988 was awarded to a local hospital with limited patient outreach in 1997. West Alabama Health Services appealed the decision and an outside reviewer

determined that the contract should have been awarded to WAHS. The state then qualified the criteria that WAHS must outscore the competing organization by over ten points, and while WAHS did rate higher than the other organization, it was within a 10 point difference. The ultimate decision was made by a toss of a coin, and WAHS lost the contract. The loss of the Maternity Waiver Program subsequently meant a revenue loss of nearly \$3,000,000.

The WAHS organizational structure was significantly altered after the acquisition of Family Healthcare Corporation. The CEO and Board members were retained from Family Healthcare Corporation.<sup>39</sup> Family Healthcare Corporation CEO continued to maintain the former corporation's administrative offices in Tuscaloosa and the two boards effectively operated separately. The two entities had not fully integrated by 2001. The founding WAHS CEO continued in his position until his retirement in September of 2000, when he was replaced by former CEO from Family Healthcare Corporation (DeWitt 2001a; Savage et al. 2004:393; HRSA FOIA documents).

### **Unraveling of a Black Power Structure**

West Alabama Health Services' power structure unraveled within four years of acquiring Family Healthcare Corporation. On the surface, the events leading up to the dissolution of WAHS involved financial complexities originating from (1) fiscal deficits on the part of Family Healthcare Corporation prior to their acquisition by WAHS; (2) the failure on the part of WAHS to seek prior approval from CMS for the acquisition, which resulted in the loss of all Medicare revenue for one year; (3) loss of the Medicaid maternal and perinatal contract with the state; (4) accusations of mismanagement, financial improprieties, conflicts of interest, and Medicaid fraud (not an all inclusive list) (Hayden 2001; DeWitt 2001a, 2001e, 2001m). Two site visit reports—one from early March 2001 and one conducted in late March 2001—cited serious divisions along racial lines between the two organizational Board members and administrative staff: members of

WAHS were predominately black and Family Healthcare Corporation were primarily white (Management Assistance Corporation 2001; Hayden 2001). However, both reports stressed that the problems with WAHS predated the acquisition of Family Healthcare Corporation. This is an interesting point because an evaluation conducted by consultants for HRSA in June of 1999 prior to the retirement of the original CEO but after the merger, the consultant stated,

Of the approximately 140 CHCs I've had the opportunity to visit in the last nine years, Family Healthcare of Alabama is the largest, and offers more services than any I've visited. This center is unique in that it not only provides a multitude of clinical services, but is very proactive in the various communities that it serves. One can see that this program no doubt meets not only the clinical goals set forth by HRSA, but it meets the social goals as this program is an intricate part of the communities in which it serves. . . . [The consultant concludes:] This is a program that not only provides quality health care, but is actively involved in the various communities they serve through school and church outreach programs, rural youth intervention programs, aids [sic] education programs, community presentations, the teen involvement program, and an array of other community health and services programs. [Management Assistance Corporation 1999:2,5]<sup>40</sup>

This evaluation mirrors the impression we found during our site visit in 1994, although we had serious concerns that our visit was well managed by the program leadership.<sup>41</sup> One media source (Velasco 2002d) suggests that HRSA was aware of serious deficiencies, but failed to act upon them.

A Birmingham judge appointed an "overseer," a forensic accountant to secure the organization's assets until he could determine which faction controlled the WAHS Board (DeWitt 2001k; Velasco 2001). By this point events had whirled out beyond the boundaries and control of HRSA. By May of 2001 the State of Alabama Attorney General Office and the Federal Bureau of Investigation had begun independent investigations, later joined by the U.S. department of Alcohol, Tobacco, and Firearms (Hayden 2001:8; DeWitt 2001; Velasco 2001).

There is no HRSA documentation, beyond June 19, 2001 when a notice of termination of WASH's CHC grant effective June 30, 2001 was sent to Family HealthCare.<sup>42</sup> A series of newspaper articles out of Birmingham and Tuscaloosa from April 2001 to April 2002 remain as

a narrative of the events. Contacts at the Bureau of Primary Health Care (HRSA) have been instructed not to discuss the case. One media source close to the turbulent end of the agency (interviewed in September of 2007) said “no one is talking and no one has been charged.” Subsequent interviews (2007-2008) with two white participants revealed that the white dominant view of the events was based on a belief that the situation was a result of a black culture of corruption and entitlement, the notion that the blacks sought personal profit, and the belief that blacks were “given license by the federal government to do whatever they wanted” and were “untouchable.”

What is clear is that HRSA and the Bureau of Primary Health Care had the political power to demand the resignation of WAHS’s Board and ultimately to close the agency by ending its financial support (DeWitt 2001b, 2001j; 2001f; DeMonia 2001). Federal dollars accounted for over half of the organization’s budget (HRSA FOIA document, Application for Federal Assistance dated September 28, 1999).<sup>43</sup> One technical assistance site report recommended that HRSA dispose of non-clinical buildings, land, and equipment; but whether HRSA had the power to do so is questionable (Management Assistance Corporation 2001:10). One Board member of the white faction was quoted as saying, “as far as I’m concerned, the federal government has come down here and put a gun to our head and said, ‘resign because you’ve been bad.’ . . . It’s Gestapo Tactics. We’ve done nothing wrong to warrant our resignation except to clean up an organization where that has been long overdue” (DeWitt 2001d). At one moment WAHS was HRSA’s darling, and in the next its albatross.

The political struggle between WAHS’s black Board members and Family Healthcare Corporation’s (the organization acquired by WAHS) white Board members was captured through the narratives of newspaper articles and the voices within. Both sides vehemently

accused the other of serious wrongdoing, each claimed to be the legal governing body of the agency. It had been a fight to the death to control an agency which the white CEO and white Board members staking a claim as sole owners—an agency they claimed was financially ruined. The black Board claimed they were the original “owners,” thus the rightful owners. When the Bureau of Primary Health Care demanded the CEO and all Board members resign in an attempt to reorganize the agency, the black faction complied, the white faction refused (DeWitt 2001b, 2001d, 2001i; Reeves 2001). The fight entered the courts (DeWitt 2001k, 2001l; Velasco 2001, 2002a,b,c).

The fight went deeper than WAHS. In Eutaw, Alabama (Greene County), where WAHS was based and the organization was part of the fabric of the community. The organization served blacks and was owned by blacks. The white Family Healthcare Board members were external to Greene County’s black catchment area serving three years on the Board, while WAHS’s black Board members represented nearly thirty years of providing services—social as well as health care—to blacks in primarily local communities. According to a HRSA site visit report conducted in March of 2001, the Eutaw community had a “negative view” of the white CEO who had replaced the original founding CEO (Management Assistance Corporation 2001:4). The report stated,

[The community] belief is that all financial problems and those having to do with downsizing, including the communities’ perspective that decisions were based on bias and prejudice is largely due to the fact that the CEO has done little to keep employees informed or to ‘bond’ with the various ‘publics.’ The fact that there are no community relations activities and members of the communities served by FHCA do not know the CEO allows Center management to be defined solely by statements made by disgruntled individuals. [Management Assistance Corporation 2001:4]

The racial distrust ran deep. Community blacks were pitted against federal and state authorities and an alien white Board. Ultimately, the white faction legally won the fight to control the agency (Velasco 2002b,c).

Their acquisition of control came after the federal government had identified and funded two health entities to cover the former WAHS catchment area: Capstone Rural Health Center in Walker County and Whatley Health Services in Tuscaloosa (Savage et al. 2004). According to one well-placed informant from the Board of Directors of Family Healthcare Corporation, the federal funding agency declined to grant support to reopen WAHS centers because the board of directors was not integrated, but all white. The WAHS facilities remain vacant and ownership of these real estate assets remains under litigation (personal communication 2008).

There were socioeconomic and health outcome improvements in several areas in the primary catchment county (Greene) from 1990 to 2000. Poverty and unemployment, for example, declined from 54.7% to 40.3% and 13.8% to 7.9% respectively (U.S. Census Bureau 1993c; 2007d). In addition, the most current data available provide evidence of significant improvements in Greene County's black educational attainment status and dramatic improvement in black infant mortality. In 1990 black educational attainment for the population 25 years or older did not reach 50% (47.6%), yet a decade later, nearly 60% (59.6%) of the black population had achieved a high school diploma or higher (U.S. Census Bureau 1993c; 2007f). Although there remained a marked educational difference between the white and black population (white educational attainment was at 80.7% by 2000). Black infant mortality rates (three year averages) for Greene County have followed a positive trend during the operation of WAHS. The black infant mortality rate for Greene County for the time period of 1982-84, a decade prior to the site visit, was 38.5 per 1,000 live births. At the time of the site visit, 1992-94, it was 14.4 per 1,000 live births. Post site visit and before the organization lost its Medicaid Maternity Waiver program to provide perinatal services to the community, 1996-98, it had declined to 6.8 per 1,000 live births. The latest data, 2003-05 and 2004-06, demonstrate

increases to 9.1 and 11.7 per 1,000 live births respectively (CDC 2008, Alabama Department of Public Health 2007). These statistics suggest the program had a positive effect on the health of the black population in the county.

The WAHS case study, for good or for bad, provides an example of conflicting policies at national, state, and local levels that control the health care process at the local level and the scars that were left behind when the system failed. The termination of the organization left a large health care void where once a robust system existed. Eight years after the failure of WAHS, the resultant cultural tensions continue to block the advancement of the impoverished population.

Table 6-1. Selected demographics, 1990: United States, Alabama, and West Alabama Health Services' Catchment Area.

	Total Pop	Square Miles	People Per Sq. Mile	White %	African American %	Rural %
U.S.	248,709,873	3,537,438	70.3	80.30	12.00	25
AL	4,040,578	50,744	79.6	73.60	25.30	40
<b>Choctaw</b>	<b>16,018</b>	<b>913.6</b>	<b>17.5</b>	<b>55.60</b>	<b>44.20</b>	<b>100</b>
<b>Greene</b>	<b>10,153</b>	<b>646</b>	<b>15.7</b>	<b>19.40</b>	<b>80.60</b>	<b>100</b>
<b>Hale</b>	<b>15,498</b>	<b>643.8</b>	<b>24.1</b>	<b>40.40</b>	<b>59.50</b>	<b>80</b>
<b>Lowndes</b>	<b>12,658</b>	<b>718</b>	<b>17.6</b>	<b>25.20</b>	<b>74.70</b>	<b>100</b>
<b>Marengo</b>	<b>23,084</b>	<b>977.1</b>	<b>23.6</b>	<b>49.00</b>	<b>50.90</b>	<b>56</b>
<b>Sumter</b>	<b>16,174</b>	<b>905</b>	<b>17.9</b>	<b>29.40</b>	<b>70.30</b>	<b>58</b>

Sources: U.S. Census Bureau 1993a:1, 4, 6, 7. 1990 Census of Population: Social and Economic Characteristics, United States. Washington, DC: U.S. Census Bureau; U.S. Census Bureau 1993c:1, 39-40, 35-36. 1990 Census of Population: Social and Economic Characteristics, Alabama. Washington, DC: U.S. Census Bureau; U.S. Census Bureau 1992d:12, 14, 16-17, 19. 1990 Census of Population: General Population Characteristics, Alabama. Washington, DC: U.S. Census Bureau; U.S. Census Bureau P001. Persons - Universe: Persons Data Set: 1990 Summary Tape File 3 (STF) - Sample Data. Electronic document, accessed February 2007. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-2. Poverty levels as a percentage of the population, 1990: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population %	White %	Black %
U.S.	13.1	9.8	29.5
AL	18.3	11.7	37.7
<b>Choctaw</b>	<b>30.2</b>	<b>15.8</b>	<b>48.4</b>
<b>Greene</b>	<b>45.6</b>	<b>7.6</b>	<b>54.7</b>
<b>Hale</b>	<b>35.6</b>	<b>12.8</b>	<b>50.9</b>
<b>Lowndes</b>	<b>38.6</b>	<b>5.6</b>	<b>49.8</b>
<b>Marengo</b>	<b>30.0</b>	<b>9.7</b>	<b>49.6</b>
<b>Sumter</b>	<b>39.7</b>	<b>12.4</b>	<b>50.4</b>

Sources: U.S. Census Bureau (1993a:3, 6, 7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993c:7-8, 35-36, 39-40) *1990 Census of Population, Social and Economic Characteristics, Alabama*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-3. Per capita incomes, 1990: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	\$14,420	\$15,687	\$8,859
AL	\$11,486	\$13,235	\$6,473
<b>Choctaw</b>	<b>\$9,622</b>	<b>\$12,264</b>	<b>\$6,291</b>
<b>Greene</b>	<b>\$6,306</b>	<b>\$13,265</b>	<b>\$4,637</b>
<b>Hale</b>	<b>\$8,164</b>	<b>\$12,967</b>	<b>\$4,925</b>
<b>Lowndes</b>	<b>\$6,848</b>	<b>\$14,829</b>	<b>\$4,153</b>
<b>Marengo</b>	<b>\$9,242</b>	<b>\$17,341</b>	<b>\$5,284</b>
<b>Sumter</b>	<b>\$8,031</b>	<b>\$13,467</b>	<b>\$5,772</b>

Sources: U.S. Census Bureau (1993a:3, 6, 7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993c:35-36, 39-40) *1990 Census of Population, Social and Economic Characteristics, Alabama*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-4. Unemployment rates as a percentage of the population 16 years and older, 1990: United States, Alabama, West Alabama Health Services' catchment area.

	Total population %	White %	Black %
U.S.	6.3	5.2	12.9
AL	6.9	5.0	13.4
<b>Choctaw</b>	<b>11.3</b>	<b>7.5</b>	<b>18.0</b>
<b>Greene</b>	<b>10.5</b>	<b>2.1</b>	<b>13.8</b>
<b>Hale</b>	<b>6.9</b>	<b>2.1</b>	<b>11.1</b>
<b>Lowndes</b>	<b>11.7</b>	<b>4.2</b>	<b>15.5</b>
<b>Marengo</b>	<b>7.7</b>	<b>2.8</b>	<b>14.2</b>
<b>Sumter</b>	<b>10.7</b>	<b>4.2</b>	<b>14.8</b>

Sources: U.S. Census Bureau (1993a:2, 7, 9) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993c:3-6, 35-36, 39-40) *1990 Census of Population, Social and Economic Characteristics, Alabama*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-5. Educational attainment as a percentage of the population 25 years or older with a high school education or higher, 1990: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population %	White %	Black %
U.S.	75.2	77.9	63.1
AL	66.9	70.3	54.6
<b>Choctaw</b>	<b>54.3</b>	<b>62.9</b>	<b>41.0</b>
<b>Greene</b>	<b>53.8</b>	<b>71.9</b>	<b>47.6</b>
<b>Hale</b>	<b>54.5</b>	<b>67.1</b>	<b>43.2</b>
<b>Lowndes</b>	<b>56.7</b>	<b>77.1</b>	<b>46.6</b>
<b>Marengo</b>	<b>61.4</b>	<b>82.4</b>	<b>43.9</b>
<b>Sumter</b>	<b>52.4</b>	<b>77.3</b>	<b>39.8</b>

Sources: U.S. Census Bureau (1993a:1, 6, 7) *1990 Census of Population, Social and Economic Characteristics, United States*. Washington, D.C.:U.S. Department of Commerce; U.S. Census Bureau (1993c:1-2, 35-36, 39-40) *1990 Census of Population, Social and Economic Characteristics, Alabama*. Washington, D.C.:U.S. Department of Commerce. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-6. Mortality rates for all causes, age-adjusted per 100,000 of the population, three year averages for the years 1992-1994 United States: Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	914.9	886.6	1,220.7
AL	1,003.9	947.9	1,222.1
<b>Choctaw</b>	<b>1,003.1</b>	<b>933.9</b>	<b>1,129.9</b>
<b>Greene</b>	<b>1,104.1</b>	<b>953.8</b>	<b>1,167.5</b>
<b>Hale</b>	<b>1,101.1</b>	<b>907.2</b>	<b>1,280.8</b>
<b>Lowndes</b>	<b>1,133.3</b>	<b>867.2</b>	<b>1,277.0</b>
<b>Marengo</b>	<b>1,052.7</b>	<b>976.4</b>	<b>1,166.5</b>
<b>Sumter</b>	<b>988.3</b>	<b>800.2</b>	<b>1,078.3</b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-7. Heart disease mortality rates, age-adjusted per 100,000 of the population, three year averages for the years 1992-1994: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	303.2	298.3	373.4
AL	329.5	320.8	370.2
<b>Choctaw</b>	<b>367.1</b>	<b>373.2</b>	<b>371.7</b>
<b>Greene</b>	<b>438.8</b>	<b>389.0</b>	<b>468.2</b>
<b>Hale</b>	<b>402.5</b>	<b>331.2</b>	<b>477.1</b>
<b>Lowndes</b>	<b>455.3</b>	<b>341.8</b>	<b>523.7</b>
<b>Marengo</b>	<b>305.4</b>	<b>266.8</b>	<b>361.0</b>
<b>Sumter</b>	<b>282.8</b>	<b>286.3</b>	<b>281.1</b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Note: Areas in bold areas are persistent poverty counties.)

Table 6-8. Cancer mortality rates, age-adjusted per 100,000 of the population, three year averages for the years 1992-1994: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	215.9	211.9	277.0
AL	224.4	213.1	271.8
<b>Choctaw<sup>a</sup></b>	<b>233.6</b>	<b>196.5</b>	<b>296.6</b>
<b>Greene</b>	<b>225.9</b>	<b>197.3<sup>b</sup></b>	<b>240.2</b>
<b>Hale</b>	<b>235.7</b>	<b>184.1</b>	<b>284.3</b>
<b>Lowndes</b>	<b>216.9</b>	<b>203.6</b>	<b>228.4</b>
<b>Marengo</b>	<b>239.4</b>	<b>227.3</b>	<b>257.0</b>
<b>Sumter</b>	<b>214.1</b>	<b>180.3</b>	<b>230.6</b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes. <sup>a</sup> Areas in bold are persistent poverty areas. <sup>b</sup> These rates were reported as unreliable by CDC. There were 19 white deaths due to cancer, and the CDC considers a death rate less than 20 as unreliable.)

Table 6-9. Cerebrovascular disease mortality rates, age-adjusted per 100,000 of the population, three year averages for the years 1992-1994: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	62.4	60.1	85.9
AL	69.0	63.8	91.1
<b>Choctaw<sup>a</sup></b>	<b>57.9</b>	<b>52.9<sup>b</sup></b>	<b>65.3<sup>b</sup></b>
<b>Greene</b>	<b>56.3</b>	<b>85.0<sup>b</sup></b>	<b>50.7<sup>b</sup></b>
<b>Hale</b>	<b>117.4</b>	<b>128.5</b>	<b>108.5</b>
<b>Lowndes</b>	<b>72.0</b>	<b>68.4<sup>b</sup></b>	<b>77.1<sup>b</sup></b>
<b>Marengo</b>	<b>122.0</b>	<b>71.9</b>	<b>178.3</b>
<b>Sumter</b>	<b>72.3</b>	<b>25.4<sup>b</sup></b>	<b>97.6</b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes. <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> The rates were reported as unreliable by the CDC.)

Table 6-10. Suicide mortality rates, age-adjusted per 100,000 of the population, three year averages for the years 1992-1994: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	12.0	12.8	7.0
AL	12.7	14.3	7.4
<b>Choctaw<sup>a</sup></b>	<b>14.9<sup>b</sup></b>	<b>25.3<sup>b</sup></b>	<b>no data available</b>
<b>Greene</b>	<b>16.6<sup>b</sup></b>	<b>27.0<sup>b</sup></b>	<b>12.0<sup>b</sup></b>
<b>Hale</b>	<b>15.0<sup>b</sup></b>	<b>25.0<sup>b</sup></b>	<b>7.2<sup>b</sup></b>
<b>Lowndes</b>	<b>14.3<sup>b</sup></b>	<b>6.7<sup>b</sup></b>	<b>17.2<sup>b</sup></b>
<b>Marengo</b>	<b>5.7<sup>b</sup></b>	<b>10.0<sup>b</sup></b>	<b>2.6<sup>b</sup></b>
<b>Sumter</b>	<b>9.7<sup>b</sup></b>	<b>21.4<sup>b</sup></b>	<b>3.8<sup>b</sup></b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes. <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> The suicide mortality rates for the entire catchment area were unreliable due to the small number of deaths over the three year period.)

Table 6-11. Infant mortality rates, per 1,000 live births, three year averages for the years 1992-1994: United States, Alabama, and West Alabama Health Services' catchment area.

	Total population	White	Black
U.S.	8.3	6.8	16.4
AL	10.3	7.5	15.9
<b>Choctaw<sup>a</sup></b>	<b>13.4<sup>b</sup></b>	<b>6.6<sup>b</sup></b>	<b>18.9<sup>b</sup></b>
<b>Greene</b>	<b>12.8<sup>b</sup></b>	<b>no data available</b>	<b>14.4<sup>b</sup></b>
<b>Hale</b>	<b>15.8<sup>b</sup></b>	<b>15.1<sup>b</sup></b>	<b>16.0<sup>b</sup></b>
<b>Lowndes</b>	<b>9.7<sup>b</sup></b>	<b>9.0<sup>b</sup></b>	<b>9.9<sup>b</sup></b>
<b>Marengo</b>	<b>12.8<sup>b</sup></b>	<b>7.2<sup>b</sup></b>	<b>15.9<sup>b</sup></b>
<b>Sumter</b>	<b>20.4<sup>b</sup></b>	<b>6.0<sup>b</sup></b>	<b>24.0<sup>b</sup></b>

Source: Centers for Disease and Prevention, CDC Wonder compressed mortality file 1979 to 1998, <http://wonder.cdc.gov/cmfi-icd9/>, accessed March 2008. (Notes: <sup>a</sup> Areas in bold are persistent poverty counties. <sup>b</sup> The infant mortality rates for the entire catchment area were unreliable due to the small number of deaths over the three year period.)



A.



B.

Figure 6-1. West Alabama Health Services' administrative offices. A) Previous offices B) Historical house purchased and renovated by West Alabama Health Services used as administrative offices in 1994. (Note: Photograph by Susan Morfit, 1994.)

## Notes

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<sup>1</sup> Although historically cotton was a bustling business in Greene County, most of the counties in the catchment area produced more than Greene (U.S. Census Bureau 1908:30; 1942:331, 333, 334; U.S. Census Bureau 1999:335, 338-340, 342).

<sup>2</sup> Alabama was the King of Cotton—in 1849—the number one state in the U.S. for cotton production based on bales produced. By 1859 Alabama had dropped to number two, by 1899 to fourth (U.S. Census Bureau 1910:26).

<sup>3</sup> The division of Greene County resulted in a relatively even population distribution between the two counties. Greene's population was 3,393 smaller (18,399) compared to Hale's (21,792). The distribution of whites to blacks remains stable for the two counties: Greene County's black population was 79% and Hale's was 78% (U.S. Census Bureau 1872:11).

<sup>4</sup> The stated statistics are for blacks who are full farm owners. If part owners are included, the picture remains bleak: blacks control 27% of the farms and 7.2% of the acres of farmland in Greene County (USDA 1994b:166, 435).

<sup>5</sup> As a comparison to Greene County's 1992 cotton production, in 1880 Greene County devoted 63,643 acres to cotton production and produced 15, 811 bales of cotton. This production was after the Civil War and a portion of the land area of the county was diminished due to the creation of Hale County in 1867 (U.S. Census Bureau 1884:4).

<sup>6</sup> The comparison is between white national poverty level and white catchment area poverty levels.

<sup>7</sup> The reference is to black per capita incomes for counties in the catchment area.

<sup>8</sup> All mortality rates, with the exception of Infant mortality rates, are age-adjusted per 100,000 of the selected population, three year averages for the years 1992 to 1994. Infant mortality rates are crude rates per 1,000 live births.

<sup>9</sup> ICD-9 codes 390-398, 402, 404-429 were used for diseases of the heart mortality rates.

<sup>10</sup> ICD-9 codes 140-239 were used for cancer mortality rates.

<sup>11</sup> The CDC reported this rate as unreliable. There were 19 white deaths due to cancer in Greene County, and the CDC considers a death rate less than 20 as unreliable.

<sup>12</sup> ICD-9 codes 430-438 were used for cerebrovascular rates.

<sup>13</sup> ICD-9 codes E950-E959 were used for suicide rates.

<sup>14</sup> Deaths due to suicide for the aggregate county populations ranged from 7 to 4 deaths in the three year period of 1992 to 1994.

<sup>15</sup> Infant mortality rates were derived from the CDC Wonder database and are crude rates per 1,000 live births.

<sup>16</sup> All of the infant mortality rates in the catchment area were based on fewer than 20 deaths. There was no data reported for Choctaw's white infant mortality rate; therefore Choctaw was omitted from the analysis.

<sup>17</sup> President Johnson was instrumental in establishing many federal programs to help protect vulnerable populations. The most visible programs are Medicare and Medicaid. It was with his direct intervention that Congress passed the legislation authorizing the programs, carrying forward President Kennedy's passion for providing health care to the elderly and poor (Litman and Roberts 1997:129).

<sup>18</sup> The white citizens who vehemently opposed the Southwest Alabama Farmers Cooperative (and later the Federation of Southern Cooperatives) were white ruling elite families, families who had controlled Sumter County

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for generations. Black farmers, under the cooperative, had become mobilized (politically and agriculturally) to protect their interests. In response, whites in Sumter County (a group that included some outside stakeholders), asked the governor to intervene.

<sup>19</sup> Michael Clemons (1998) argues the Federation of Southern Cooperatives created political mobilization in the Black Belt region—and it did—but not without controversy. Whites mobilized very early to block progress for the organization, even its funding on numerous occasions (see Bethell 1982).

<sup>20</sup> One outside source (Savage, Duncan, and Ford 2004:392) states the agency's name was originally West Alabama Health Services Project and was changed in February 1985 to West Alabama Health Services.

<sup>21</sup> For example, the period from 1976 to 1980, infant mortality rate for the area was 28.2 per 1,000 live births (Leeper, Nagy, and Hulett 1988:2).

<sup>22</sup> We had requested an organizational chart of the agency, list of the Board of Directors, and a copy of their budget. None of the items was obtained.

<sup>23</sup> The agency had been “studied” by many visitors. It had a national reputation of being an exemplary agency and community health clinic. I later learned that the director of the Office of Rural Health Policy had visited the site as well. The longstanding agency personnel were very well versed in providing interviews to visitors. The most candid interview was with the executive director.

<sup>24</sup> We were provided access to the agency's key physician, the senior grant writer, the programs director (acting in the role of non-clinical administrator), and the executive director of the agency for interviews.

<sup>25</sup> It is worth repeating that the catchment area covered nearly 6,000 square miles. For example, the distance from the administrative offices and the core primary care center in Greene County to Lowndes County is 120 miles, 90 miles to Choctaw County.

<sup>26</sup> The primary doctors practicing at the Maddox community health center in 1994 were: three family practitioners, an intern, a pediatrician, a dentist, and a part-time podiatrist.

<sup>27</sup> The consortium was funded by the Robert Wood Johnson Foundation from 1987 to 1991. The program continued as an informal consortium after the funding stream ceased (American Hospital Association 1993:13).

<sup>28</sup> Members of the West Alabama Rural Consortium (based in Eutaw) were the following: Bibb Medical Center (Centreville), College of Community Health Sciences (University of Alabama School of Medicine, Tuscaloosa), DCH Regional Medical School (Tuscaloosa), Fayette County Hospital (Fayette), Greene County Commission (Eutaw County government), Greene County Hospital and Nursing Home (Eutaw), West Alabama Health Services (Eutaw), Perry County Hospital and Nursing Home (Marion), Health Development Corporation (Tuscaloosa), and Hill Hospital of York (York).

<sup>29</sup> A number of the clinical practitioners we interviewed were originally National Health Service Corp placements from the Public Health Service.

<sup>30</sup> West Alabama Health Services acquired the funding for the West Alabama Rural Health Consortium and developed a network system of resources.

<sup>31</sup> West Alabama Health Services gave preference to minority students in hiring post graduates.

<sup>32</sup> Federal funding paid for operational and maintenance expenses, as well as for reimbursement of patient encounters.

<sup>33</sup> Before West Alabama Health Services was established, there were no obstetrical and gynecological services in the catchment area. As a family practitioner, she assumed the responsibilities of providing those services. Primary care and family physicians employed by the agency provided perinatal services for routine pregnancies. There was one nurse-midwife, a new addition to West Alabama Health Services who would, among other duties, perform

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deliveries within the hospital setting. One informant stated there was no interest within the community for home births. The nurse-midwife was not interviewed by the research team.

<sup>34</sup> Walking clubs had been organized through community churches, for example.

<sup>35</sup> The county school system was extremely conservative, with an abstinence only policy.

<sup>36</sup> It is somewhat interesting that the academic component was named the “Saturday Academy” because the “academies” in the rural South were a euphemism for white private schools, which were quickly organized after desegregation was instituted.

<sup>37</sup> One of my last tasks at the Office of Rural Policy was to provide data on health care resources in West Alabama as a briefing for the Congressional delegate by the ORHP Director during the tour of the area.

<sup>38</sup> The document is a WAHS site visit report contracted by HRSA, Bureau of Primary Health Care with Management Assistance Corporation. The site visit was conducted March 6, 2001 to March 8, 2001.

<sup>39</sup> The CEO was the only administrative personnel retained after the merger.

<sup>40</sup> The report was based on a five day site visit.

<sup>41</sup> WAHS had many constant “visitors” touring the facilities, and it appeared the “tour” had become rote.

<sup>42</sup> Document obtained from HRSA, Bureau of Primary Health Care through the Freedom of Information Act, dated June 19, 2001.

<sup>43</sup> WAHS’s budget for fiscal year 2000 was \$11,797,781: the federal contribution through CHC funding was \$6,100,000 (51.7%); the state contribution was \$600,487 (five percent); \$1,414,927 was derived from “other” sources (12%); and program income was listed as \$3,682,367 (31.2%) (HRSA FOIA document, Application for Federal Assistance dated September 28, 1999).

## CHAPTER 7 DISCUSSION AND RECOMMENDATIONS

### **Discussion and Analysis**

This dissertation examines federal policies through time, delineating their corporal linkages to local communities, through the use of the heuristic model developed in Chapter 1 based on a political economy of health paradigm. Specifically, the discussion and analysis follow the network of influences from the historical context to the local community as outlined in the concentric rings of the model: (1) Historical Context, (2) Political Economy, (3) Racism and Poverty, (4) Community Programs, and (5) Measurable Outcomes (Health of Community Members). This examination explains how federal policies interact with and respond to historical macro-forces such as political power inequities, racism, low educational levels, and poverty to shape the delivery of health care in three rural areas within the southern United States. Moreover, the data presented in this dissertation provide substantive examples of how the dynamic process of federal policies directly influences and circumscribes micro health programs within the three communities, resulting in tenuous accessibility at best for the most vulnerable individuals. This is not a recent phenomenon but is deeply embedded in the historical legacy of the U.S. health care system (Litman and Robins 1997).

### **Historical Context**

The macro-historical context of the contemporary U.S. health care system is a consequence of nearly one hundred years of unsuccessful attempts to legislate universal health care, resulting in a patchwork of incrementally developed health policies predicated on complex political and economic factors rather than on a unified concept of government support for total population health care goals (see Chapter 3, p. 56; see also, Table 3-3). Unlike health systems in other industrialized nations, the U.S. health care system is not based on an underlying philosophy of

social responsibility of the government for the immediate provision of health services to the population. The American government does not guarantee the right to health care, but asserts that it is an individual responsibility, leaving many citizens with too little educational and economic resources to ensure their capability to fully participate in the functioning of the total community. Instead of establishing a comprehensive and unified program ensuring health care for all, the federal government funded a wide variety of smaller programs specifically tailored to individual target groups (Table 3-1). The three cases reported here are examples of such specifically targeted programs. In the late 1970s and the early 1980s, the U.S. government funded community health centers in two of the case study communities to provide health services to medically underserved populations. The third case study was a successful program in which the program leadership attempted to avoid overt dependence on direct federal funding, but still received extensive indirect federal funding, primarily through block grants to the state.

The need for intervention in health service access for all three case studies resulted from the isolation of the target groups in areas where available medical services were essentially absent. The concentration of indigent populations in these areas is a historical result of agricultural policies as well as the result of slavery and the dissolution of the plantation system in the South. In the case of Bebé Sano, which is related to agricultural business and immigration policies, Hispanics fill an occupational niche analogous to the black agricultural workers of the Old South. The recruitment of labor from Mexico dates from the 1800s with the building of the railroads in the southwest and progressed to employment of Hispanics in the rich agricultural areas opened up to rail commerce with the northeastern U.S. markets (see Driscoll 1999; Galarza 1978 [1964]; Gonzales 1999; McWilliams 1968). The undocumented Hispanic migrants of the late 1900s were thus on an equal footing with the newly liberated blacks of the 1860s with no

legal rights and few opportunities. The applicability of the Civil Rights legislation of the 1960s did not apply to undocumented Hispanic migrant workers as it did to black slaves and their descendants.

All three target populations had a deep historical distrust of outside intervention, particularly by the federal and state governments, due to historical situations which left the populations in a rather vulnerable and precarious fiscal and social status. In the case of Children and Family Services, the development of the agency was deeply influenced by this distrust of government which was considered unreliable and invasive, eventually becoming bureaucratized and limiting the scope of community assistance. For example, the director maintained complete control at the local level feeling that state and federal programs would usurp her authority and limit her ability to direct the agency to fill self-identified needs. This policy choice of self-sufficiency ultimately limited the capacity to serve a larger population. Similar distrust of outside influences was evident in all three cases and could be tied to historical power inequities, in some cases dating back for well over a century, or even back to the founding of the country. Such power inequities between white and black races date from Colonial times, while after the Civil War the invasion of carpetbaggers into Southern communities for the expressed purpose of reestablishment of the Southern economy and social infrastructure subjugated to Union ideals did not endear the federal government to many Southerners (Morris 1996; Ruef and Fletcher 2003; U.S. Commission on Civil Rights 1983).

The general historical milieu thus includes political considerations such as state's rights issues, Civil Rights laws, economic turf wars, and immigration policies, which are viewed differently between the North and the South. Political issues unrelated to the programs discussed in this study can have a direct effect on indigent health programs simply due to the political

haggling and compromises that may result in funding or lack of funding for a specific program regardless of its intrinsic merit. For example in Alabama, state authorities objected to the federal program establishing a Public Health Service clinic (WAHS) in Greene County as an usurpation of state prerogatives and a perceived economic threat to the state medical establishment (see Chapter 6:191-192; see also, Wiener et al. 1998). This dispute involved state officials, the federal government, AMA, Alabama Medical Society, and local community leaders, both white and black.

At the micro-historical level, all the cases were closely tied to their macro-historical backgrounds. However the details of the local perceptions and historical influences were also closely tied to specific aspects of local geography, local population structure, agricultural economy, and politics. Greene County retains a large part of its antebellum heritage, protected from destruction in the Civil War by its surrounding rivers. The 80% black population is reflective of the use of black slave labor on the plantations. Even the distribution of wealth and social status reflects its pre-Civil War structure. All of these factors contributed to the social, political, and economic fabric in which the WAHS was established and within which it was expected to operate.

### **Political Economy**

Political and economic forces, arising within the democratic and capitalistic culture of U.S. society, permeate and are intrinsic to the U.S. health care system at every level. Given the power hierarchy of governments at national, state, and local levels, the authority at the federal level typically supersedes state and local authority. Local requirements often come into conflict with federal policies when they are applied to very specific local conditions. For example, in Cocke County the need for temporary agricultural workers conflicted with federal immigration policies, stimulating extensive employment of illegal undocumented migrant workers from Central

America to harvest crops in the absence of cheap local sources of labor. This conflict between the needs of the local agricultural economy and federal immigration policies led to isolation of the undocumented workers from the local community and denial of access to local health care providers. This gap in support of migrant workers was the stimulus for the creation of the Bebé Sano program, which was designed to use federal funds to provide some health protection for the labor pool supporting local agricultural interests. Interplay between forces and structures at all levels of government and economy provide a complex, fluid network of relationships which form the basis for the success or failure of rural health programs for vulnerable, marginalized populations. This network of relationships sets limits on what the programs under study here were capable of accomplishing. This was clearly demonstrated in all three case studies.

In both case studies involving indigent black populations, black leaders took control of their destiny in an atmosphere of historically entrenched “differences,” where the minority white population continued to control the wealth, the land, and the region, where blacks continued to be non-citizens. Both programs represented a social experiment which was empowered by the protection of federal laws passed through the Civil Rights movement. The enactment of both programs was accompanied by a critical shift in national policies to address historical institutional inequalities. For example in Alabama, power structures at the federal, state, and local levels were drawn into direct conflict by changing social ethics at the federal level not shared by the state. Federal Civil Rights laws preempted state political attempts to maintain and perpetuate historical racial segregation and the policies intended to keep the black population “in their place.” The federal policies endangered the traditional racial and economic status quo in Alabama. Governor Wallace, at that time, was intent on reversing federal laws affording blacks a better opportunity to participate in the larger society and economy. Thus, WAHS’ humble

beginning was embarked upon by the newly empowered black community leaders, after the Civil Rights legislation was passed, leading to the eventual development of a robust primary health care system for poor black communities in West Alabama, an impressive feat against formidable opposition both in the state government and state medical community.

The relationships between the programs and the federal government differed widely in the extent that the federal government officials had direct fiscal and administrative oversight. In its early years, WAHS was supported by fervent technical and financial patronage through the United States Department of Health, Education, and Welfare (antecedent to HHS). On the other hand, the relationship between Children and Family Services and the federal government was ambiguous. The agency and its programs were not mandated by the federal government—in fact there was a deep seeded mistrust of the federal government—but came about in response to rising expectations and awareness by local black leaders who found new political authority engendered through the passage of Civil Rights legislation. Although not directly supported by federal executive agencies, Children and Family Services' programs enjoyed access to federal funds through block grants to the states and through grants from other public and private sources, which served to shelter the organization from direct federal evaluation and intervention. The favorable federal climate toward programs assisting impoverished blacks facilitated access to funding sources and gave the program some political protection from state and local groups seeking to deny services to blacks. Denial of child care services to blacks in Tipton County was directly related to the genesis of Children and Family Services, which led to the implementation of the Enrichment and Intervention program for indigent medically disabled infants. The federal passage of Public Law 108-446, titled Individuals with Disabilities Education Improvement Act

of 2004, replicates and funds efforts in all states similar to the director's Enrichment and Intervention program, validating her original vision in 1985.

The original *Bebé Sano* maternal health program was a top-down, unfunded federal intervention to protect the health of migrant farmworker dependents, women of child bearing age and their infants. It differed from the other two case studies in that it was founded on a federal mandate, without direct federal funding, to an organization that concurrently received other federal funding. This made the funding relationships between each of the organizations and the federal government distinctly different. The intervention in the *Bebé Sano* case could be viewed as a humanitarian act by a benevolent government or as a gesture to protect agribusiness to insure a continued flow of critical labor resources. In 1992, Tennessee held top national rankings for tobacco and tomato crop production, crops that require large investments of cheap, temporary labor for harvesting (see Chapter 4). The program was in essence a capital investment to ensure the availability of workers, and was tightly bound with ties to political and economic agendas.

Although the community health center supporting the *Bebé Sano* already provided services to the local largely-white poor, federally mandated expansion to cover Hispanic migrant farmworkers met with strong resistance. Resistance was particularly strong among the local patients who felt that the Hispanics were receiving special treatment and that they were infringing on the white population's ability to receive timely medical care. Although these allegations may have had some minor degree of merit, the opposition was met with equal determination from dedicated staff and some influential community leaders, and the program continued to provide assistance to the disadvantaged migrant workers. Inflammatory statements by prominent state political leaders reinforced the public perception. Subtle social and economic

pressures sought to undermine staff dedication, mainly by threatening loss of portions of the white patient clientele of providers who also served the migrant farmworkers. Overall, the persistence and conviction of most staff members, energized by the federal mandate and the implicit threat that failure to comply would complicate continued federal funding for their programs and support for other operations essential to the organization, was sufficient to assure continued operation and success of the Bebé Sano program. The federal mandate pitted rather powerless staff against an executive agency that controlled the center's future funding.

None of the three cases were self supporting, and all required large outside funding sources to remain solvent and to stay in operation. All three programs had some form of client payment scheme, but none were sufficiently large to represent a significant source of funding. Support from Medicaid programs differed widely among the three cases. Children and Family Services was not directly reimbursed by Medicaid, but the recruitment of health care providers willing to deliver services to the organization's indigent clients was severely impaired by the extremely low Medicaid reimbursement rates in Tennessee.<sup>1</sup> The other two organizations with community health centers depended extensively on reimbursement from state-run Medicaid programs for a large portion of their income. Federal regulations required that the community health centers provide treatment to all who sought it regardless of the ability to pay. In Tennessee Medicaid reimbursement rates were extremely low, but in Alabama high reimbursement rates made Medicaid a large source of revenue for WAHS, at least until 1997. Medicaid reimbursement to the Bebé Sano program was more complicated since a large portion of their clients were undocumented aliens. With the passage of the Deficit Reduction Act of 2005, only those persons who can produce identification verifying they are U.S. citizens have access to Medicaid (Kaiser Family Foundation 2006). Prior to enactment of this law, Medicaid reimbursements were made

for all emergency services for life threatening events, including infant delivery, to the uninsured regardless of eligibility. This legislative change, which TennCare as of 2007 interprets as excluding treatment of all life threatening events for the undocumented, places the Bebé Sano case in a difficult position, since they must continue to treat patients regardless of Medicaid eligibility, but are denied reimbursement for all non-citizen migrant farmworkers. Non-citizen migrant women continue to have babies, but are no longer covered by Medicaid in the program's catchment area regardless of their visa status. The migrant workers continue to seek treatment, but lack of Medicaid reimbursement for many of them places a severe strain on the organization's resources. The conflict between the federal requirement to treat patients and the Medicaid restriction against reimbursement for treatment of all aliens places the organization, and the health center by which it is supported, in jeopardy of insolvency. The federal government, by issuing the State of Tennessee a demonstration waiver to design their own state Medicaid program with subsequent renewals, has placed Rural Medical Services, and community health centers across the state, in a position to assume more financial responsibility with larger case loads, while receiving fewer federal and state dollars.

Power inequities were evident not only between different levels of government, but also at the micro-community level within organizations and within local communities. Unequal distribution of wealth and resources were evident within the communities in all three cases, with deep divisions along racial and ethnic lines. The effects of deeply held ethnic biases within the local community in Cocke County were a constant concern to the leadership of the Bebé Sano program. Although the organization gained legitimacy and acquired a political base of its own as it grew, declining economic conditions and growing xenophobia in the media and the national consciousness caused shifts in local power bases. Public perception that the undocumented

Hispanic migrant workers were undeserving of public support quickly limited the willingness of local health providers to perform pro bono treatment to the agency's clients. As another slightly different example of shifting power inequities, WAHS developed deep divisions in its leadership along racial lines after the merger with Family HealthCare Services. The bitter struggle between the two factions led to loss of backing among former influential supporters of the program both locally and in Washington. This shift from support to opposition crept up from the local power structure to the national level and culminated dramatically in loss of funding, fiscal insolvency, and closure. The power inequities that drove the rise and fall of WAHS were not only racial and economic, but also derived some of their impact from pure governmental politics, from traditional class structure in the state, religious distinctions, disparate educational attainment levels, and many other differences between the black and white populations. However, at the micro-community level, race and economic status were the most pervasive, consistent, and important forces operating to influence the founding, operation, and sustainability of programs within each of the case studies.

### **Poverty and Racism**

Represented in the third ring of the model, poverty and racism directly impact local health care availability. They influence power and economic relationships in each of the rings of this model. They arise from the historical situations that generated the current cultural status of the population. They influence the mindset of actors at all levels either consciously or unconsciously, generating powerful concept-based policy biases that often pit state authorities, local community leaders, and federal policy makers against each other and force sometimes unlikely alliances and compromises. As public perceptions, educational levels, and economic conditions change, systematic changes in policy development also occur. Public attitudes toward immigrant farmworkers provide an excellent example of how provision of health services to

indigent populations can garner nation-wide attention and engender intense pressure to pass legislation denying government-funded health care services to noncitizens. The poverty and racism ring correspond to prominent sociocultural forces and structures inherent to the persistent poverty counties under review. Intergenerational poverty and institutionalized racism were the main root causes of the sociocultural circumstances that gave rise to the local programs examined in this study.

In two of the case studies, the power inequities between the poor blacks and the dominant white power structure were inherited from their historical situation. Blacks in these case studies were born into poverty and racial inequality. Most had seen little outside their local community and had little knowledge of options available to improve their situation. Migrant workers in Tennessee were in a similar position since they often did not understand the political situation surrounding them, and they did not know what their options were; that is, they lacked cultural capital. From their position at the bottom of the power structures in their local areas, the blacks shared power inequities with the local white population, with state officials whose loyalties often lay within the broader white power structure, with federal officials, and even with assistance agencies which shared backgrounds and goals that were not necessarily synchronous with those of the black community.

Likewise, the migrants faced power inequities with the growers, contract crew chiefs, government officials, and even the clinic staff themselves, who also represented persons of authority with strong government connections. Although powerful in their own right due to their wealth and position as major landowners and local taxpayers, growers were also in conflict with immigration services, creating a three way power triangle between the migrants, the growers and the immigration officials. Interest conflicts between the growers and the immigration office

forced the growers to keep the migrant laborers isolated with as low public visibility as possible. In the three way interaction, the migrant workers lacked agency and generally were at the lowest point of the power structure.

The pervasiveness of the power inequities in the three case studies in effect acted to reinforce the black and migrant farmworker communities' lack of cultural capital and the persistence of lower health expectations, and to preserve the political and economic status quo. To be effective in the long term, the programs needed to address non-health-related deficits that also resulted directly from these power inequities, such as low educational attainment and unemployment that immediately reinforced the cycle of poor health expectations. All of the case studies had an active outreach program integral and essential to their operation. These outreach programs extended far beyond identification of patients needing specific treatment. Sparse educational opportunities in the effectively segregated school systems in Alabama and Tennessee left the target youth in particular with a low employment outlook, as well as insufficient training in basic public health and hygiene practices. Therefore, training programs in all three cases extended well beyond health and hygiene and into personal economics, acquisition of social skills and improved work ethic, and broader understanding of the wider American cultural milieu, as reflected in WAHS' Teen Involvement program and Children and Family Services' Bright Futures Supportive Services program. The intent was to give the youth tools that would help them improve their economic status and provide a standard of living more consistent with a healthy life style. In the case of Bebé Sano, similar outreach programs concentrated more on health issues and social services, but because of the transient nature of the target population broader educational programs were less appropriate.

The director of Children and Family Services, for example, applied lessons she had learned while accompanying her husband in his military career postings worldwide, in an attempt to improve the future outlook for the black population in her organization's catchment area. Willingness to accept the status quo and lack of educational attainment needed to improve the situation, were two of the large contributors to the persistence of poverty. In addition to the passage of federal equal rights and equal opportunities legislation, widespread access to public media such as television, radio, and the print media stimulated social change and facilitated the establishment of these programs. Rapid communications also exposed racially repressive activities and gave some protection to those seeking to correct social inequalities. In all three case studies, without strong federal policy support for Civil Rights legislation outside of the Deep South (i.e., nationwide) and rapid critical media exposure of repression, it is unlikely that any of these programs would have had significant success.

Racism in the form of ethnic prejudices toward migrant farmworkers in eastern Tennessee followed a similar pattern experienced by blacks in the South, with notable exceptions. Unlike blacks who were lifelong residents within communities of the rural South, Hispanic migrant farmworkers were viewed as aliens, and federal laws which protect black rights did not extend to undocumented aliens. National perceptions of illegal immigrants draining public dollars from federal, state, and local governments, real or imagined, have ignited a national debate of "who belongs" and "who does not." Tennessee was not immune to the politicizing of immigration issues. Elected Tennessee government officials (from the U.S. Congress and Tennessee State Legislature) publicly cast Hispanics in Tennessee as invading Mexican aliens, and as such they did not deserve the same rights to Tennessee governmental resources as did native Tennesseans (see Chapter 4 Addendum). Inflammatory ethnically biased statements from elected officials

served to further polarize public opinion across Tennessee, especially in small rural towns where migrant farmworkers continually returned over the previous 23 years to harvest crops, with increasing numbers of migrant farmworkers choosing to permanently settle in Tennessee rural and urban communities. The increased bigotry directed at Mexicans through such official discourses served to amplify Appalachian beliefs of the “other” and the perceived legitimate right of the natives to exclude alien migrant farmworkers from their community. With the U.S. government leadership failing to dissuade the American public of these misconceptions, providing health care to migrant farmworkers in Appalachian Counties will be much more difficult to finance, provide, and sustain in such a volatile atmosphere.

Federal policies against racism and ethnic hatred, as expressed in laws governing nearly all facets of life including housing, employment, access to goods and services, access to education, political activity, rights to legal representation, and protection against physical abuse, have greatly eased the plight of blacks and Hispanics across the country, but racism and ethnic hatred are still alive and well in the areas served by these three case examples. Although the government can legislate behavior to some extent, it cannot directly legislate morality. In all three case studies, the establishment of community health and social programs explicitly to serve indigent racial and ethnic minorities was a first attempt to fill a recognized void in their catchment areas. This in itself was a significant event much beyond the actual health care outcomes. All three programs were well accepted and used by their target populations. As a concretized example of the new horizons opening for these persistent poverty populations, these programs achieved high public visibility and gained political authority in their own right, giving added legitimacy to the efforts of the population to improve their economic and political condition. Nevertheless, changes in racial and ethnic perceptions and biases in the Deep South

will continue to be slow, while real equality between races and ethnic groups in all three organizations' catchment areas is still a dream for the future.

In summary, racism and poverty were equally apparent and equally obstructive in all cases. They were co-confounders in each case. The strong racial and ethnical discrimination patterns were a surprising result of this study, as the cases were chosen on the basis of persistent poverty rather than racial or ethnic criteria. Both forces have acted historically to limit access to health care, and continue to negatively impact the populations in all three locations. The ultimate failure of WAHS program was a serious setback for indigent health care programs in that location, even though responsibility for similar primary health services was transferred to Whatley Health Services. The scandal and accusations of malfeasance can be expected to have severe negative impact on support for local black run social organizations throughout the state for a long time due to mutual racial distrust. Overall, it proved impossible to evaluate the effectiveness of the programs without considering race and poverty issues as they interacted to reinforce each other.

### **Community Programs**

The fourth ring of the model considers the organization and operation of the individual case studies as well as their interactions with the local community and with the larger political, economic, and historical milieu. In this discussion, the primary focus will be on the similarities and differences between the organizations from their founding to the present time in an attempt to discern the important factors that constitute an effective, reproducible, and sustainable community health program, which could be viewed as a model for programs in persistent poverty rural areas as part of a larger nationally-based health care system. Because of the extreme needs in these localities and their severe social and economic isolation, these case studies provide insight into specific problems that may be overlooked if the establishment of

rural health centers is based on needs in areas that are more racially and ethnically integrated and more economically advantaged.

All three organizations arose from efforts that were initiated outside the local dominant power structure. Bebé Sano and WAHS originated outside of the community as mandates from the federal government. Children and Family Services on the other hand developed from grassroots efforts within the community, but through the determined initiative of the founder, who was not initially part of the power structure, but rather a black social activist, proud of her reputation as a “trouble-maker.” Challenging the local status quo, she formed a community-based, service oriented, economic development agency, after a review of potential funding sources and completion of a needs assessment. None of the three cases were initiated by local or state governmental authority and none would have been established without powerful intervention by forces outside the local and state governments and health care establishments.

### **Charismatic leadership**

Because of the political and social conditions in the local communities, organizations providing health services to persistent poverty communities needed strong charismatic leadership to give it credibility in the community, to promote the program goals and services to the target population, to secure funding, to attract and select qualified and dedicated employees, and to provide a champion for the program. The charismatic leaders observed in this research possessed a deep commitment to the communities they served; they were dedicated, dynamic, resourceful, innovative, and persistent. In all three cases, charismatic leaders arose from within the community. In the Children and Family Services case, the organization formed around a self-identified community activist directly. In the other two cases, federal officials from HHS, cognizant of the needs in the communities, intervened to identify local persons who were positioned to assume leadership in projected federal programs. Criteria for selection of leaders

for specific programs varied greatly from one case to another. This is evident in the wide range of the qualifications among the leaders in these three cases, varying from a high school diploma, to a college degree, to an advanced degree in public health and health care administration.

Because of the deep penetration of racial and ethnic issues through all levels within the model, race and ethnicity played an important role in gaining effective access to the target populations, thus influencing the choice of leadership. Black residents in isolated areas and Hispanic migrant workers are less likely to respond positively to white outreach workers than to members of their own racial or ethnic group. From a different perspective, the preferential selection of leadership with such a heavy emphasis on racial and ethnic criteria is directly in opposition to and clearly conflicts with the civil rights and equal opportunity laws and policies of the federal government and may also be contrary to state and local regulations. All three organizations showed preference in hiring on racial and ethnic criteria. In the selection of the charismatic founders and principal leaders, this did not appear to be an immediate issue in these cases. In the design of this research, the cases were chosen from among existing programs in which nearly all had strong racial or ethnic components already in their leadership. The Bebé Sano case appeared to be somewhat of an exception, since it was staffed largely by persons from the local, predominately white (*anglo*) community, but the primary outreach contact was Hispanic. In this case, the target population was transient and fairly uniform in its lack of technical and professional personnel capable of providing program leadership from within its own numbers. However, the organization's CEO, who had prior experience in Public Health Service clinics serving isolated indigent populations (namely, Native Americans), was a suitable charismatic leader identified from among the local resident population. Although he was not

himself Hispanic, he worked actively to enhance the cultural competence of the staff, for example, by encouraging employment of Hispanic and Spanish speaking staff members.

This discussion may seem to suggest that there was a conscious effort to go out into the population to find charismatic leaders. This was not the case. In all three cases, the founding of each organization varied somewhat from the others, but it could be said that the organizations grew around suitable individuals in a symbiotic fashion. The establishment of these programs was not happenstance but rather the result of dedication, insight, and persistence of the individuals involved in their beginnings. But it could also be said that the individual charismatic leaders were creative in directing the growth of the organization in response to their perception of the needs of their community. Such a process requires that the individual entrusted with forming and nurturing the fledgling organization must have considerable cultural capital and cultural competence in dealing with the specific needs of the target population.

### **Cultural capital**

The founding charismatic leaders in each of the cases had considerable cultural capital, as all were established in the community, with extensive knowledge of and ability to do business in the local economic and political circumstances. In this sense, they stood out sharply from the vast majority of the members of the program's target population. The concept of cultural capital, for the purposes of this analysis, refers to the subject's understanding of social and economic relationships within a culture necessary to survive and prosper within that culture. It includes both a social network of personal relationships with other members of the collective community as well as the ability to operate within the network of organizations and agencies that make up the political and economic fabric of the culture (see Massey 2000; Massey, Goldring, and Durand 1994; Fussell 2004). Leaders of all three organizations possessed extensive cultural capital but to differing degrees in each case. The director of Rural Health Services, as CEO of

the preexisting and well established CHC in Cocke County, had vast cultural capital because of his intimate knowledge of the local community, in addition to extensive technical training and professional experience providing health services to marginalized populations. He had a broad understanding of issues and procedures at all levels of government and professional organizations, and had an established network of contacts and relationships with government offices and health care agencies with resources needed to sustain the clinic operations. More importantly, the CEO had comprehensive expertise in rural health care delivery in the context of wider state and national policies and programs. In contrast, the founder of WAHS was less well endowed with cultural capital, but as principal of a local public secondary school, he had an intimate knowledge of the community and understood local budgeting and political processes. While he had little prior knowledge of health care delivery programs, he was able to attract staff with skills and access to health professional networks that he did not possess. In the case of Children and Family Services, the founder possessed a robust network of relationships through her community connections, her professional connections as a state health outreach worker, and her experiences as a political activist. What she lacked in formal education she made up for in both experience and her ability to challenge the local political status quo. Cultural capital is a prerequisite for sustaining a community health program within the larger political and economic setting, but cultural competence is a prerequisite for effective access to the target population and for facilitation of productive contact between the health providers and the rural poor (see, National Center for Cultural Competence 2008a, 2008b).

### **Cultural competence**

Cultural competence is required at the interface between the provider staff and the client, and represents the level of trust and credibility held between the caregiver and the patient. As stated above, members of isolated rural persistent poverty communities tend to be more receptive

to health providers with whom they share racial, ethnic, and cultural similarities. The conscious awareness of belief systems, behaviors, linguistics, ethics, religion, emotions, and other specifics of the target population's culture is absolutely essential for health providers working in outreach programs to vulnerable populations. Outsiders who understand the nuances of the local culture and can employ this knowledge to facilitate productive contact with the local community are said to be culturally competent (Borovoy and Hines 2008:3; National Center for Cultural Competence 2008a, 2008b; Shaw 2005; van Willigen 2002:129). In the Children and Family Services and the WAHS cases, personnel were recruited primarily from the local population. Sensitivity to local cultural nuances was not an issue, for the most part. For WAHS it became a serious problem after the expansion to include the white clientele and staff of Family HealthCare Corporation, and lack of cultural competence between the two racial factions contributed greatly to the decline of the organization. In the *Bebé Sano* case, cultural and linguistic dissimilarities between the staff and the Hispanic patients were critical issues. The CEO of Rural Health Services did not have a prior background in dealing with the Hispanic culture, but was well aware of the need for sensitivity. He actively hired culturally competent staff and encouraged development of cultural competence within the existing staff. For example, by 2003, lay health promoters from the local Hispanic community had been hired to assist the clinic staff with behavioral health outreach to the migrant farmworker population. Close attention to issues of cultural competence was critical to the effectiveness and long term sustainability of the *Bebé Sano* program. The CEO of Rural Health Services, which included *Bebé Sano*, embodied every requirement to fulfill the criteria for both cultural capital and cultural competence.

### **Program funding**

None of the cases had consistent funding sources that would sustain their operations over the long term without reapplication for a new grant, and none came close to being self-

supporting. All three organizations collaborated with local religious and charitable organizations to some extent either to support activities directly or to assist in outreach programs. Even after many years of operations, funding remained ephemeral, consuming large amounts of time and organizational resources. Private sources for funding or benevolent activities of local churches and charities are impacted heavily by national economic conditions, and due to the persistent poverty in the catchment area, local charitable infrastructure was already strained. Donor fatigue is also a limiting factor in long term support for charitable causes. Although the data does not clearly demonstrate such instability in private funding, the economy during this period was generally strong and robust enough to sustain at least the minimum required funding. What seems to be clear is the need for permanent and sustainable support. Whatever the source, funding came with restrictions and could not be used to cover expenses outside a carefully prescribed set of applications. West Alabama Health Services, and the other two to lesser extents, had extensive requirements to support their broad holistic array of services. Juggling funds to cover expenditures not specifically permitted within the prescribed limits was a temptation that required, but did not always receive, close attention by the funding source. Numerous allegations of improprieties were made against WAHS in the years prior to its closure in 2001, but were neither reflected in early formal evaluations and audits nor legally proven.

### **Program evaluation**

Evaluation of the success of a program was primarily based on reports from the program administrator. There was insufficient program evaluation in at least one case: the WAHS failure. Reports from the community health center to the granting authority stressed the considerable accomplishments, including numbers of patient encounters, a summary of fiscal data, a review of staff and facilities, and projections of future planning. According to at least two informants, in this case, site visits and independent fiscal audits were conducted in a friendly atmosphere and

were well staged. This allowed the organization to provide essentially a ‘Potemkin village’ assessment which concealed deficiencies that would have alerted officials much earlier than was the case—that irregularities in the use of funds and other administrative errors were indeed occurring. The evaluator needs to have access to the records and documentation of past activities and must have direct open access to staff and employees to the extent required to perform a balanced critical evaluation of the operations.

### **Fundamental factors essential for sustainability of rural health programs in persistent poverty counties in the South**

Data indicate there are key factors that must be met to sustain community health programs in persistent poverty counties in the rural South. In 1994, all three programs were successful entities and shared striking commonalities. With the subsequent failure of WAHS, the important role these factors played became increasingly transparent. Sustainability requires strong charismatic leadership, cultural capital, cultural competence, stringent oversight and evaluation, and consistently dependable funding. Without any one of these factors the organization is unsustainable. All of these factors were present in all three cases at the time of the site visits in 1994. Lack of rigorous oversight, both internal and external, was perhaps the first failure in the WAHS case, and incrementally the organization lost its cultural capital, cultural competence, charismatic leadership, and sources of fiscal support. The proposed theoretical model for this research discusses interrelationships between forces within all rings of the model. These interactions play a key role in reinforcing each of the sustainability factors listed here. Like the forces in the model, these sustainability factors are interdependent.

By building a trusting relationship with the target populations, each of the programs had a satisfied client base that depended on the organization for health care services. Each of these programs had been providing services for at least nine years prior to the site visits. Many of the

programs developed by the three cases were long term projects. These included some of the teen pregnancy prevention programs, as well as, educational and career training programs that required persistent long term efforts. These long term projects required steady funding to produce cultural changes

Initially the fate of the organization depends largely on the founder. Long term sustainability requires that other competent charismatic leaders be mentored and trained so that a new leader with dedication, charisma, cultural capital and cultural competence can effectively guide the organization after the departure of the founder. When the founding CEO of West Alabama Health Services retired in 2000, leadership passed to the former chairman of Family HealthCare Corporation. As a white administrator who had formally administered community health centers for white clients, he did not possess the required cultural competence to interact effectively with the largely black population and did little to gain the trust and confidence of the local black population. He became the scapegoat for the fiscal difficulties of the organization, the downsizing of operations, and large staff reductions.

### **Measurable Outcomes**

Each of the case study agencies demonstrated significant success, at least in the mid 1990s. Even the West Alabama Health Service provided quality medical services and held the respect and support of the client population—their demise was technically unrelated to the quality of medical services. In the absence of access to long term longitudinal health studies measuring changes in disease incidence and prevalence as well as mortality rate comparisons over successive years, this study relies largely on limited data for individual counties obtained through the state health departments as reported to the CDC and on less direct indicators such as numbers of client encounters as reported by the programs themselves. Number of patient encounters was high and all three organizations had a robust flow of clientele. The continued high utilization of

each of the programs is a basic indicator of patient satisfaction. Children and Family Services even had waiting lists for many of their programs.

The data suggest that Children and Family Services had a measurable effect on some indicators of black youth health status. While Tipton County blacks had a higher overall mortality rate than the white majority population, black infant mortality had declined significantly by 2006, whereas the white infant mortality rate remained essentially unchanged since 1994. Children and Family Services' programs specifically targeted the excessive high black teenage pregnancy rates. Successful black teenage pregnancy rate reduction, by nearly one half from 1994 to 2006, greatly lowered the load of poor health consequences on black youth and increased the potential for overall improvements in the status of the black community. In contrast to the *Bebé Sano* case where the whole population rotated annually, the Children and Family Services clientele was stable and the improvements in health status remained in the community, where they could be built upon by future efforts.

The diverse programs of WAHS gave it the potential for producing immense change in the health and wellbeing of the poor black population. However, the data demonstrated that in no case did the mortality rates for the black population ever approach the more favorable levels observed in the white population. The drop in the black infant mortality rates between the three data points 1982-86, 1992-94, 1996-98, with a subsequent rises following the close of operations, 2003-05 and 2004-06, supports the conclusion that the organization was effective while it was in operation (see Chapter 6 Addendum for rates).<sup>2</sup> Ancillary social programs were an essential part of the holistic approach of WAHS for improvement of health expectations and well being of the community. These also demonstrated successful outcomes particularly in the increase of educational attainment, and decrease of the overall unemployment rates among

blacks. The demise of the organization in 2001 essentially left the county without adequate local health care services and without the much needed ancillary programs supporting and augmenting them. The intense public reaction from the black community in support of WAHS when it ceased operations attested to the high degree of community dependence on the organization and its efforts to improve their wellbeing (DeWitt 2001m).

For different social and historical reasons, the Hispanic migrant farmworkers experienced a similar isolation and diminished opportunities to escape the cycle of poverty and poor health expectation. The intense outreach efforts of the Bebé Sano program focused primarily on perinatal care and health education, but also provided limited access to career and other educational programs from other sources.<sup>3</sup> However, the itinerancy of the migrant workers and their long hours in the field made intensive intervention outside of perinatal services difficult.

The indigent, particularly the Hispanic migrant workers, may not understand the political relationships and geopolitical boundaries and how they affect funding and reimbursement. Federal policy makers often do not take this into account when writing laws covering health care availability. Without the migrant maternal child health program, the Hispanic migrant farmworker patients would have received no care at all. So in the Bebé Sano case, migrant farmworkers were directed to the Cocke County hospital which was nearest the clinic, which had an inordinately large indigent case load, including 26 uncompensated births in 2007. These uncompensated births reflect the fact that, for political and economic reasons, hospitals in other counties in the catchment area were reluctant to treat migrant farmworkers (Table 4-7). This high number of uncompensated births represents only one class of Bebé Sano's referrals and indicated the extent of success the organization had in obtaining needed health services for the migrant population, as well as the high fiscal burden this places on medical providers in the

catchment area. The unwillingness of the hospitals in neighboring counties to treat the indigent and migrant workers is a reflection of the need for changes in health care policies on a wider, perhaps nation-wide, scale to insure that the poor who comprise a large portion of the population—particularly in the South—not do fall through the health care safety net, such as it is.

### **Recommendations**

Applied medical anthropology was not employed in the design of programs in these three cases. It is the function and responsibility of the applied anthropologist to explore differences between cultures co-existing in contested space, such as seen in these case studies, and to recommend solutions to mitigate those differences. The following recommendations are proposed for policy makers and leaders of impoverished communities to improve design and outcome performance of government supported health programs intended to mitigate health decrements resulting from persistent poverty among racial and ethnic groups.

#### **Recommendation 1: Model for Federally Supported Sustainable Health Programs in Persistent Poverty Counties in the Rural South**

This recommendation proposes a model for federally funded health programs. The framework of this model is based on the research findings of the dissertation and consists of five primary components which must be present for a sustainable rural health program as discussed above in the Community Programs section. These essential components or variables include:

1. Charismatic Leadership:
  - a. Dedicated
  - b. Dynamic
  - c. Willing to challenge the existing power structure, status quo
  - d. Able to attract dedicated employees
  - e. Innovative and adaptable
  - f. Visionary
  - g. Advocate
2. Cultural Capital:

- a. Experience/education to administer the program (e.g., expert knowledge)
  - b. Vested member of the community
  - c. Demonstrated ability to network and form collaborative linkages with potential advocates of the project
  - d. Knowledge of political and economic relationships at all levels
  - e. Understanding of community needs and resources
  - f. Ability to set and achieve realistic goals for the community
  - g. Adept at public relations
3. Cultural Competence:
- a. Awareness of local beliefs and behaviors unique to the locality and target population
  - b. Sensitivity to cultural differences
  - c. Collaboration and engagement with target population
  - d. Good listener and astute observer
  - e. Linguistic competence
4. Funding:
- a. Consistent and reliable
  - b. Sufficient
  - c. Longer term funding
  - d. Diverse sources
  - e. Sliding scale copayments
  - f. Ultimate goal of self-sustaining operations
5. Oversight and Evaluation:
- a. Robust oversight of financial management
  - b. Periodic site visit evaluation by applied anthropologist
  - c. Assessment of patient records
  - d. Assurance of quality care by monitoring patient outcomes
  - e. Provision of technical assistance and remediation of deficiencies noted in site visits

The first three of these components apply directly to the choice of leadership for the organization. They are culturally embedded in the specific community and difficult to ascertain solely from a written grant application. The last two cover a broader array of program operations responsive to but not limited to leadership questions.

All five components require the establishment and application of federal policies to provide support and guidance to federally funded rural health programs. The consideration of these components (requirements) should be firmly and explicitly stated in the policies employed to establish and maintain federally funded programs intended to mitigate poor health among

vulnerable populations. Federal policy must include guarantees that each of these requirements will be assessed and evaluated by trained and proficient anthropologists who can verify that the requirements have been met and recommend remedial measures if inadequacies are found.

Typically, grant applications are reviewed by an expert panel and awarded on the merits of the application. For the proposed model to be effective, final review of grant applications should be considered only after a thorough interdisciplinary site visit has been conducted on the applications selected for detailed consideration.<sup>4</sup> As part of the interdisciplinary team, the anthropologist would be responsible for ethnographic site visits using rapid assessment procedures to ascertain that the requisite anthropological relevant factors are present *prior* to grant approval and funding. Moreover, a comprehensive ethnographic site visit would identify cultural issues that could support or hamper the proposed program including, for example, strength of political and economic relationships, proposed linkages with collaborative partners within the community, and potential racial and ethnic conflicts. Once the initial site visit has been conducted, the anthropologist should be included on the grant review board to voice recommendations on the soundness of the proposed program.

Funding is clearly essential for program sustainability. The anthropologist's role in funding evaluation is twofold. First, an anthropologist can assess that the self-identified needs of the population are appropriately met through the array of services to be provided at the expected level of funding. Second, the anthropologist can identify cultural tendencies that may interfere with the proper use of the available resources. These may include an overly aggressive sense of entitlement, lax recordkeeping, nepotism, and other abuses that may lead to ethical and political failures that could threaten the organization's reputation and lead to sustainability issues.

In the case of CHCs that operate on a five-year grant, HRSA relies on an annual continuation application to evaluate the progress of the program. While the continuation application is comprehensive, the information is self-reported. For greater objectivity and to validate the completeness and accuracy of annual applications, annual on-site ethnographic program evaluations for federally funded health programs are necessary and must be conducted as a matter of routine, and more frequently—perhaps every six months—in cases of deficiencies, to assess the degree to which the project staff have met the stated requirements and to propose actions to correct any noted deficiencies.<sup>5</sup> These evaluations help to ensure the ongoing viability of programs, but only if they are sufficiently detailed and independent of manipulation by the program leadership to expose basic operational deficiencies that can then be addressed.

At present, HRSA is pursuing cooperative agreements with state and regional primary care associations to provide technical assistance to community health centers (HRSA 2008c). While this is a positive step in enhancing the viability of centers across the nation, it does not guarantee the most impoverished counties will have access to this service. For this reason, funding should be allotted within the grant structure to provide for structured continuing education for program leaders. The heart of the training should focus on ethnic and cultural competence, ethics, methods for fostering total community commitment and solidarity, and other cultural issues as well as organizational skills, business management, and other procedural and technical issues.<sup>6</sup> Opportunities for program leaders or identified future leaders to participate in internship programs in similar or related projects at different locales would also provide them with important insight into cultural and organizational factors leading to program success. Such training would also alert program administrators about pitfalls which could lead to program failure. Applied anthropologists are integral for the training program.

The federal program for community health centers nationwide currently costs the government two billion dollars annually and rising (HHS 2008c:19). Ideally, community health centers should be established as part of a universal health care program to assure access to primary health care for all citizens and non-citizens alike, ensuring a basic minimum level of health care for all, as needed to keep the social and economic engine of the community functioning at an acceptable capacity. It is easy to assert that such a program would reap long term savings by assuring that basic health prevention methods kept the population more productive and less in need of extensive curative medical intervention. Proof for this is more difficult to acquire and is beyond the scope of this dissertation. The ultimate goal would be to achieve self sufficiency either under the current insurance based payment system, or as a tax supported component of a national universal health care system. It is conceivable that in many persistent poverty areas, any form of self sufficiency can be achieved only with dedicated intervention in the local economy over many years within the current insurance based paradigm. The model presented here represents an initial starting point for establishment of an integral component of a national health system designed to provide permanent relief for the most vulnerable poor populations in the country. The support of this system must be a permanent budget item funded from year to year, and evaluated regularly to guarantee that the funds are being properly used to effectively raise the basic health of the poor population.

### **Recommendation 2: Collaboration between HRSA and Applied Anthropologists**

Government employment of applied anthropologists in support of health care improvement programs working for the government is well documented (Fiske 2008). Within the agencies of HHS, anthropologists are most visible at CDC, which employs approximately 55 to 65 anthropologists (Fiske 2008:115). This fruitful affiliation is reflected in collaborative CDC projects such as, the Planned Approach to Community Health program (PATCH) (Kreuter 1992;

see Chapter 6) and Mobilizing for Action through Planning and Partnerships (MAPP) (NACCHO 2008). On the other hand, the work of anthropologists in HRSA is less visible, although historically HRSA has relied on anthropologists as contractors for specific tasks (Needle et al. 2001; Singer 2000a,b; Trotter 1987; Trotter et al. 2001).

HRSA is engaged in funding a wide range of community-based health programs, especially in persistent poverty areas and should include applied anthropologists in all aspects of this process. Analogous to the concept of continuity of care in the provision of clinical health care services, anthropologists should be permanent employees of the agency, versus short-term consultants, to provide consistent, integrated services throughout the granting process. The use of applied medical anthropologists improves success of programs by providing critical cultural insight at key stages of the grant process, ensuring that critical aspects of cultural relations are optimized and that unintended consequences of unforeseen cultural conflicts are minimized. Applied anthropologists with skills in ethnography, needs assessment, program evaluation, cultural competency, cultural brokerage, and conflict resolution guarantee funding agencies access to reliable culturally competent expertise (Chambers 1989: 165-167; LeCompte et al. 1999; Trotter 1988, 1991; van Willigen 2002:129-40; Whiteford 1991).<sup>7</sup> These anthropological skills can be employed to provide critical data to assess the cultural impact of community issues and beliefs on the individual project being funded. The inclusion of anthropologists in the establishment of persistent poverty health programs as well as their participation in monitoring program performance may increase the likelihood of long-term success. In this role, the anthropologist functions as an advocate for the government, while facilitating the needs of the community.

### **Recommendation 3: Collaboration between Community Health Programs and University Medical Centers**

HRSA should require that all federally funded community health centers establish linkages with regional academic medical centers. Academic medical centers are a source of clinical resources that can benefit the programs providing health services to the rural poor as well as provide training and research opportunities for medical practitioners. Such programs are not new and were used to some extent in two of the case studies. Cooperative and collaborative programs for training clinical practitioners—such as medical residents, medical students, nurses, pharmacists, dentists, as well as other allied health practitioners—within rural clinics provide clear benefits for all parties involved. Such collaboration provides vulnerable rural counties, especially persistent poverty counties, with an expansion of clinical resources at the same line providing medical practitioners with valuable experience in realities of rural medicine. Furthermore, as the health care field becomes increasingly more technological and more or less remote from individualistic concepts of health and well being, service in rural clinics that do not have immediate access to state of the art technology available at major urban hospitals provides medical practitioners with a constructive experience in humanistic medicine. The training also benefits the clinic staff and stimulates the rural practitioners to maintain academic currency. Telemedicine also provides rural health providers with convenient access to specialist opinions at reasonable cost to the rural clinic. The expansion of the use of nearby resources provides a means of augmenting limited means in a cost effective manner.

### **Recommendation 4: Collaboration between Persistent Poverty Community Health Programs and Applied Anthropologists**

Anthropology departments at regional universities, especially departments of applied anthropology, provide a unique array of resources for community health programs. For example, the community health program staff may request university anthropology departments to provide

assistance in the assessment and resolution of specific issues within the community that impact the clinic's ability to provide care. While this may be viewed as an arcane use of applied anthropologists in consideration of the wide roles applied anthropologists are engaged in outside academia, for impoverished communities with scant fiscal resources, this linkage would be economically realistic (see, for example, Chambers 1989; Fiske 2008; Kedia 2008; Sabloff 2000; and van Willigen 2002 for descriptions of the many roles of applied anthropology). In this context, the role of the anthropologist is as an advocate for the health center and the community—advocates for the disenfranchised. Numerous university-based applied anthropologists are committed to assisting communities in a wide range of community challenges. At the University of Kentucky, where John van Willigen has influenced applied anthropology, the anthropology department specializes in contemporary applied themes including medical anthropology, political economy, social organization, and cultural complexity. The department research areas include “Critical Studies in Health,” “Power, Economies, and Governance,” “Identities and Transnational Flows,” and “Gender and Social Relations” (University of Kentucky, Department of Anthropology 2008). At the University of Memphis, which is logistically close to the Children and Family Services program, the faculty have proficiency in topical areas such as “ethnic identity”; “community development”; “social justice”; “identity, politics, and mobilization”; “participatory action research”; “medical anthropology”; “family health”; “community development and poverty”; “non-profits/NGOs”; research design and evaluation”; “race and social inequality”; “human rights”; “community health and evaluation”; and “impact assessment” (University of Memphis, Department of Anthropology 2008). At the University of Alabama in Tuscaloosa, the anthropology department has a long history of applied anthropology and community studies. It was at University of Alabama that

Solon Kimball developed a strong research interest in southern communities publishing *The Talladega Story: A Study of Community Process* (1954), an action participatory research project that enlisted community members to identify public health needs (Moore 1984). Kimball was a prominent leader in applied anthropology and was a founder of the Society of Applied Anthropology in 1940 (Moore 1984; University of Alabama, Department of Anthropology 2008). Today, the department of anthropology retains a strong applied focus with a specialization in medical anthropology (University of Alabama, Department of Anthropology 2008). Similar action participatory research projects would be invaluable in assisting local health care professionals and community leaders in impoverished areas to resolve conflicts impacting healthcare improvement within their communities (See, Gibson 2002; Schensul et al 1987).

Assertive and self-motivated program leaders, applied anthropologists, and responsible community activists can make use of a wide array of resources readily available on the internet. Encouragement of such continuing education and life-long learning is essential to assure that program leaders and staff continue to provide the optimum support and assistance to the communities they serve. Self-help manuals and on-line resources may assist community health program leaders, as well as applied anthropologists, in developing and sustaining health programs in persistent poverty areas. These resources may support and compliment the direct involvement of applied anthropologists in the field. The following brief discussion illustrates some example of currently available resources. The University of Kansas' Work Group for Community Health and Development (<http://ctb.ku.edu>) provides an on-line resource, the Community Tool Box, which provides comprehensive approaches for community collaboration, capacity building, and development. The W.K. Kellogg Foundation (<http://www.wkkf.org>) has

designed *The Collective Leadership Framework: A Workbook for Cultivating and Sustaining Community Change* (2007) to guide communities in the intricacies of identifying and developing quality leadership from within the community. This workbook is available on-line and may be ordered free of charge from the organization. The Center for the Advancement of Community Based Public Health in collaboration with the CDC (<http://www.cdc.gov/eval/evalcbph.pdf>), has developed *An Evaluation Framework for Community Health Programs* to assist community health program leaders in designing their own evaluations “to more actively and aggressively participate in evaluation efforts” (CBPH 2000: Preface). The National Association of County and City Health Officials (NACCHO 2008) (<http://www.naccho.org>) in collaboration with CDC has produced a web-based tool, *Mobilizing for Action through Planning and Partnerships*, that includes a comprehensive handbook designed to assist communities in the process of improving community health. Emory University’s Center for Public Health Practice of the Rollins School of Public Health has produced *The Public Health Competency Handbook* (Nelson et al. 2002), available through Population Health Futures (<http://populationhealthfutures.com/handbook>). This handbook is designed for organizations and communities to establish and implement leadership and management processes to optimize individual and group performance in providing effective health services through the community. It deals more with facilitating successful communication and productive interaction between the providers themselves as well with their patients than with technical and scientific competence. These on-line resources will provide community and program leaders with valuable tools and information. They can increase the effectiveness of direct collaboration between applied medical anthropologists and leaders of fledgling community efforts in the process of developing and sustaining grassroots health delivery programs to vulnerable populations.

## Summary and Conclusion

Persistent poverty, particularly in rural underserved and disenfranchised racial and ethnic populations, contributes decisively to the overall poor performance of the U.S. health care system compared with industrialized countries worldwide. This study detailed interactions of federal, state, and local policies as they were implemented in three community health programs. Data from these programs providing primary health services to indigent rural populations in the Deep South were collected through ethnographic site visits and analyzed along with secondary and archival data to reveal cultural processes and factors that resulted in the success or failures in these programs. Important among these were persistent institutional racism, influence of strong charismatic leaders, political willingness of actors at multiple levels to support the programs, changing and conflicting policies in funding programs, diversity in funding requirements and funding sources, low levels of educational attainment among beneficiaries, and assessment of estimated health improvement outcomes in the target populations. Access to effective health services for the rural poor was greatly affected by the influence of persistent racism and low educational attainment. Nonetheless other factors such as charismatic leadership and strategies to obtain resources from diverse sources were effective in producing improved health and wellbeing in the target groups.

The analysis of the case studies led to development of recommendations for future application by policy makers within the current U.S. health care paradigm. Using the theories and methods of applied cultural anthropology, the goal of the recommendations is to facilitate the development of more effective programs aimed at raising the overall standing of U.S. health care in comparison with other industrialized democracies. Nearly all of these countries used paradigms of government responsibility for population health to develop universal health systems providing essential medical services to all citizens. The current use of various federal

and state projects to cobble together a diverse health support system for poor and disadvantaged populations, whether urban or rural, will continue to result in an expensive, ineffective, and unbalanced endeavor until the political will builds to make basic, systemic and undoubtedly painful changes in the philosophy and constitution underlying the U.S. health care system. Current presidential candidates have proposed plans to guarantee universal health care access based on government subsidies for private insurance for the poor, continuing the current healthcare system (Antos et al. 2008; Buchmueller et al. 2008). The presence of a Black candidate on the Democratic ticket and a female Republican candidate for vice president are important events in American cultural history, but are unlikely to produce immediate or near term reforms in the basic paradigm of the U.S. health care system.

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## Notes

<sup>1</sup> The director of Children and Family Services enlisted private physicians to provide pre-school physicals, and eye and ear examinations.

<sup>2</sup> Although cases are few, the trend suggests that WAHS had a positive influence.

<sup>3</sup> The Tennessee Opportunity Program and local Catholic Church, among others, provided employment training and assistance, English training instruction, and other social support services to migrant farmworkers and their families who were referred to them by the Bebé Sano personnel.

<sup>4</sup> The interdisciplinary team should include an applied anthropologist along with technical experts in health care administration and public health.

<sup>5</sup> John van Willigen (2002:189-204) refers to evaluation as a form of policy research to inform policy makers, and ethnographic program evaluation as a type of evaluation that uses ethnographic techniques.

<sup>6</sup> There are self-help manuals available for communities through a variety of agencies, institutions, organizations, and universities (e.g. the W.K. Kellogg Foundation, National Association for County and City Health Officials, Embry University, Kansas University, The Center for the Advancement of Community Based Public Health) that address a number of the cultural issues and will be discussed in the fourth recommendation

<sup>7</sup> John van Willigen defines cultural brokerage as, “an intervention strategy of research, training, and service that links persons of two or more sociocultural systems through an individual, with the primary goals of making community service programs more open and responsive to the needs of the community, and of improving the community’s access to resources” (van Willigen 2002:130).

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## BIOGRAPHICAL SKETCH

Susan W. Morfit was raised in Melbourne, Florida. After graduation from high school, she moved to Tampa, Florida. She attended school at Hillsborough Community College (A.A. in liberal arts), University of South Florida (B.A. in anthropology, Honors Program), University of Florida (M.A. Latin American studies, anthropology concentration), and both the University of South Florida and the University of Florida (Ph.D. anthropology programs). Along the way she raised her son, Brett Canter, and found her husband, Van Morfit. Susan currently is living in the Washington, D.C. area with her husband.