Midwives' Collaborative Activism in Two U.S. Cities, 1970-1990

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MIDWIVES' COLLABORATIVE ACTIVISM IN TWO U.S. CITIES, 1970-1990

Linda Tina Maldonado

Dr. Barbra Mann Wall, PhD, RN, FAAN

This dissertation uses historical methodologies to explore the means through which activist midwives in two northeastern cities collaborated, negotiated, and sometimes conflicted with numerous stakeholders in their struggle to reduce infant mortality. Infant mortality within the black community has been a persistent phenomenon in the United States, despite a growing dependence on advancing medical technologies and medical models of birth. Studies in the early twentieth century typically marked poverty as the dominant factor in infant mortality affecting black communities. Refusing to accept poverty as a major determinant of infant mortality within marginalized populations of women, nurse-midwives during the 1970s and 1980s harnessed momentum from the growing women's health movement and sought alternative methods toward change and improvement of infant mortality rates.

Utilizing a grassroots type of activism, midwives formed collaborative relationships with social workers, community activists, physicians, public health workers, and the affected communities themselves to assist in the processes of self-empowerment and education. Negotiating with hospital administrators and powerful physician groups, these activists were able to improve substandard medical and institutional treatment of marginalized pregnant women while pushing for alternative deliveries of obstetrical care that included the integration of nurse-midwives.

Through their work with communities of marginalized women, nurse-midwives and their collaborative partners were able to improve the consistency of prenatal care by building strong networks of advocacy and social support. As a result, communities became engaged in their health as well as self-empowered to make positive change in the health of pregnant women and infants. Equitable healthcare and persistent infant mortality in the black community are relevant and contentious concerns today. The history of nurse-midwives and health activists sheds important light onto these enduring societal problems. Furthermore, a historical understanding of successful nurse activist models is essential as the country undertakes healthcare reform that will necessarily involve nurses to improve access to care.

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Dissertation

Degree Name
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Graduate Group
Nursing

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First Advisor
Barbra Mann Wall

Keywords
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Subject Categories
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MIDWIVES’ COLLABORATIVE ACTIVISM IN TWO U.S. CITIES, 1970-1990

Linda Tina Maldonado

A DISSERTATION

in

Nursing

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy

2013

Supervisor of Dissertation

Signature________________

Dr. Barbra Mann Wall

Dr. Barbra Mann Wall, PhD, RN, FAAN, Professor of Nursing

Graduate Group Chairperson

Signature________________

Dr. Barbara J. Riegel, PhD, RN, FAAN, Professor of Nursing

Dissertation Committee

Dr. Julie Fairman, PhD, RN, FAAN, Professor of Nursing

Dr. Damon Freeman, PhD, Professor of History
Dedication

To Jacob and Joshua
ACKNOWLEDGMENTS

I have had the honor of being guided by an amazing dissertation committee and readers. To my dissertation chair, Barbra Mann Wall: thank you for your patience, encouragement, and spirit during every step of my progress. I am forever grateful that you took me under your wings. To Julie Fairman: thank you for seeing the abilities you helped nurture well before they were ever visible. Dr. Freeman: I thank you for teaching me how to approach race critically and thoughtfully. Your expertise sharpened my ability to consider nursing, community, and health through the multiplicities of race, class, and gender. Thank you to my dissertation readers: Bill McCool and Anne Teitelman. My work has benefitted greatly from both your insight and unique vantage points.

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To my family and friends who believed in me when at times, I doubted myself; I love you and thank you. You know who you are. My sons, Jacob and Joshua, bravely ventured on this life-altering journey with me six years ago. It is because of you that I accomplished this goal. Love you dearly and forever.
ABSTRACT

MIDWIVES’ COLLABORATIVE ACTIVISM IN TWO U.S. CITIES, 1970-1990

Linda Tina Maldonado

Dr. Barbra Mann Wall, PhD, RN, FAAN

This dissertation uses historical methodologies to explore the means through which activist midwives in two northeastern cities collaborated, negotiated, and sometimes conflicted with numerous stakeholders in their struggle to reduce infant mortality. Infant mortality within the black community has been a persistent phenomenon in the United States, despite a growing dependence on advancing medical technologies and medical models of birth. Studies in the early twentieth century typically marked poverty as the dominant factor in infant mortality affecting black communities. Refusing to accept poverty as a major determinant of infant mortality within marginalized populations of women, nurse-midwives during the 1970s and 1980s harnessed momentum from the growing women’s health movement and sought alternative methods toward change and improvement of infant mortality rates.

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Table 2

INFANT DEATHS

Most infant deaths occur in the neonatal period: i.e., under 28 days of life. The number and percent of infant deaths in the neonatal period are as follows*:

Table #13

<table>
<thead>
<tr>
<th></th>
<th>1978**</th>
<th>1979</th>
<th>1980</th>
<th>3 Year Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.D. #5</td>
<td>36 (72.0)</td>
<td>28 (68.3)</td>
<td>41 (72.0)</td>
<td>105 (70.3)</td>
</tr>
<tr>
<td>H.D. #6</td>
<td>23 (63.9)</td>
<td>29 (66.0)</td>
<td>20 (52.6)</td>
<td>72 (59.3)</td>
</tr>
<tr>
<td>Phila.</td>
<td>320 (74.9)</td>
<td>310 (69.3)</td>
<td>311 (69.1)</td>
<td>941 (71.0)</td>
</tr>
<tr>
<td>Penna.***</td>
<td>1540 (75.8)</td>
<td>1548 (73.0)</td>
<td>1530 (72.9)</td>
<td>4618 (73.9)</td>
</tr>
</tbody>
</table>

Note the high increase of neonatal deaths for 1980 in Health District #5. It is also interesting to note that the State of Pennsylvania has a higher percent of babies dying in the neonatal period than the City of Philadelphia. This may be due to the presence of advanced neonatal intensive care centers in our City. However, both of the Health Districts and the City have higher infant death rates than the State.

*Percentages are based on the number of neonatal deaths per total infant deaths for each area.

**Data Source from the Philadelphia Department of Health, Selected Resident Birth and Death Data by Health District, by Census Tract 1978, 1979, 1980, pp. 1 of each report.

<table>
<thead>
<tr>
<th></th>
<th>CENSUS TRACT 132</th>
<th>PHILA. HEALTH DISTRICT 5</th>
<th>PHILADELPHIA</th>
<th>PENNSYLVANIA</th>
<th>U.S.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANT DEATHS</td>
<td>34.7</td>
<td>27.3</td>
<td>18.1</td>
<td>13.2</td>
<td>12.5</td>
</tr>
<tr>
<td>(up to age 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEONATAL DEATHS</td>
<td>20.8</td>
<td>19.6</td>
<td>12.5</td>
<td>.96</td>
<td>8.4</td>
</tr>
<tr>
<td>(In first 27 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Philadelphia Dept. of Public Health, Pennsylvania Division of Health Statistics, National Center for Health Statistics
Geographical Distribution

The presence of geographical subdivisions such as Wards and Census Tracts in the District provides a basis for breaking down District-wide data into small area statistics for comparison and analyses. In the absence of individual-level socioeconomic data, these Ward statistics form a useful basis for evaluating health status indicators against demographic and environmental Ward characteristics. In 1999, there was a decrease in the number of infants born in all but three Wards of the city. The infant mortality breakdown by Ward for 1999 also shows a decline in the infant mortality rate for Wards 1, 2, 5, and 7. The infant mortality rate increased in the other four Wards (3, 4, 6 and 8). Among the four Wards with increased infant mortality rates for 1999, Ward 8 had a large increase from a rate of 11.6 in 1998 to 27.5 in 1999. The number of infant deaths increased by 18 in Ward 8 for 1999.

<table>
<thead>
<tr>
<th>Table 4: Births, Infant Deaths and Infant Mortality Rates by Ward District of Columbia Residents, 1998 and 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Infant deaths per 1,000 live births.

Note: (1) Due to the small number of infant deaths, the above infant mortality rates are highly variable and should be interpreted cautiously.

Source: D.C. State Center for Health Statistics Administration.
Table 5: Statistical Overview by Ward
District of Columbia Residents, 1999

<table>
<thead>
<tr>
<th>Ward</th>
<th>Births</th>
<th>Infant Deaths</th>
<th>IMR*</th>
<th>LBW</th>
<th>Teen Births</th>
<th>LBW to Teens</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,112</td>
<td>10</td>
<td>9.0</td>
<td>128</td>
<td>162</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>799</td>
<td>10</td>
<td>12.5</td>
<td>87</td>
<td>83</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>854</td>
<td>5</td>
<td>5.9</td>
<td>55</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>936</td>
<td>14</td>
<td>15.0</td>
<td>118</td>
<td>110</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>809</td>
<td>18</td>
<td>22.2</td>
<td>140</td>
<td>159</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>824</td>
<td>11</td>
<td>13.3</td>
<td>116</td>
<td>152</td>
<td>24</td>
</tr>
<tr>
<td>7</td>
<td>941</td>
<td>11</td>
<td>11.7</td>
<td>155</td>
<td>194</td>
<td>29</td>
</tr>
<tr>
<td>8</td>
<td>1,237</td>
<td>34</td>
<td>27.5</td>
<td>198</td>
<td>247</td>
<td>31</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>7,513</td>
<td>113</td>
<td>15.0</td>
<td>997</td>
<td>1113</td>
<td>141</td>
</tr>
</tbody>
</table>

* Infant deaths per 1,000 live births.

Notes: (1) Teen birth means birth to a mother under 20 years of age.

(2) LBW means low birth weight (under 2,500 grams or 5 lbs. 8 oz.).

(3) Due to the small number of infant deaths, the above infant mortality rates are highly variable and should be interpreted cautiously.

Source: D.C. State Center for Health Statistics Administration.
Chapter One

Midwives’ Collaborative Activism in Two U.S. Cities, 1970-1990
Introduction

Successful nursing advocacy often involves unlikely parings of polar opposites working together. Collaborations of extremely different people united toward a cause can make radical changes in nurse, client, and community. This dissertation examines the role of nurses in the women’s health movement of the 1970s and 1980s through the lens of two organizations: the Maternity Care Coalition (MCC) of Philadelphia, Pennsylvania; and the Maternity Care Association (MCA) in New York City. The MCC and MCA provided the institutional frameworks within which nurse actors operationalized their advocacy. This study adds to the multiple meanings of nurse advocacy by placing nurses as participants and leaders during the era of the women’s health movement. By considering nurse actors as representatives of their larger organizations, this study also argues for nursing’s inclusion in social movement activity.

The 1970s and 1980s were particularly important times for women’s activism. Midwife-led birth centers and women’s health clinics emerged from a national context of high maternal and infant mortality as well as rising consumer mistrust in medicine. For example, in 1980, Philadelphia’s census tract 152 witnessed an infant mortality rate of 34.7 deaths per 1000 compared to a national average of 12.5 deaths per 1000.¹

The MCC and MCA also followed in the footsteps of the grassroots community center legacy that originated in the 1960s. Bonnie Lefkowitz, in her study of Mississippi, contends that during this period, activists’ response to Mississippi’s infant mortality rates served as seeds for the community center movement’s redefinition of community health. Health was no longer limited to repair of the physical body and as such took on new meanings of prevention, access, and community based caring. The concept of community was a cornerstone for the success of these early centers.\(^2\) Following this notion of communitarianism, both the organizations in this study also embedded themselves within the communities they served.

Feminists were also challenging the medical model of birth by demanding active knowledge of their bodies and the birthing process. Their stance was in direct opposition to the traditional male physician dominated hospital environment that placed women in the role of passive recipient. In the 1970s and 1980s, several books became synonymous with a national call for birth to be reclaimed by childbearing women as well as removed from the hospital setting. Suzanne Arms’ *Immaculate Deception* and Barbara Katz Rothman’s *In Labor: Women and Power in the Birthplace* called not only for childbearing women to embrace their rights to own their birth but also admonished nurse-midwives for allowing the medicalization of the nurse-midwifery profession. Another important piece during this period that critically examined birth in the U.S. was *Our Bodies Ourselves*, about women reclaiming their bodies and also about childbearing.\(^3\)

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2 See Bonnie Lefkowitz’s *Community Health Centers: A Movement and the People Who Made it Happen*.
Despite the disdain from feminists and women’s health advocates such as Arms toward the nursing profession’s predominant image of enduring allegiance to a male dominated medical profession, there were nurses who openly identified as feminists. Nurse feminists, such as Peggy Chinn, criticized the nursing profession for being notably absent from the women’s movement and for not incorporating feminist thinking and feminist theory into its practice.\(^4\) Chinn was one of the main organizers behind the group Cassandra: Radical Feminist Nurses Network. The group was formed during a 1982 American Nurses Association convention as the result of the founders’ frustration at the convention’s seeming attention to mundane and non-important issues. Their goals included building support of nursing research employing a feminist approach while building a national network for nurse feminists to connect.\(^5\)

Yet, indeed, many nurses were not supportive of feminism, and not all nurses who were involved with feminism, social justice, and women’s health activism identified themselves as nurses to those outside of their activist work. In an oral history interview with Black Panther activist Ashanti Alston, he recalled one female, Black nurse in particular who was involved in the health activism of the Panther Party but never disclosed this information to those outside of the organization.\(^6\) Reasons for her silence could have been due to fear of retribution from her employer as well as lack of support from her fellow nursing colleagues. This research indicates that nurses were getting involved in activism, both openly as well as behind the scenes. Their voices and stories

\(^4\) Peggy L. Chinn, “Feminism and Nursing: Can Nursing Afford to Remain Aloof From the Women’s Movement?” *Nursing Outlook* 33, no. 2 (1985), 74-77.


\(^6\) Oral history interview with Ashanti Alston by Linda Maldonado on June 8, 2012.
need to be uncovered to understand how nurses during this period engaged in social movement activities.

This period also gave witness to increasing medical mistrust by women, especially minority women, towards physicians and hospital systems charged with having their best interests at heart. In addition, race continued to be a clear factor in childbirth choice during the 1970s and 1980s. For example, in 1989, 93 percent of those attended by a certified midwife were white. Wendy Kline notes that black community members often associated midwifery care with a “second-rate” type of care: an enduring legacy from the granny midwife era. Wendy Simons points out the irony in that assumption. She found that the general sense among midwives was that poor women and women of color were less likely to have their birthing desires and needs met by conventional medicine and that they had more to gain from midwifery.7 And some community women appreciated local midwives. Still, nurse-midwife-run clinics and birth centers positioned themselves as safe and nonjudgmental alternatives to medically modeled hospital systems. By placing their centers in strategic locations, these midwives were able to reach a diverse group of women.

This dissertation addresses the following questions:

(1) What social, cultural, economic, and political factors in the community shaped nurses’ advocacy alliances?

(2) What were the leadership and power structures of the organizations, and how did they influence advocacy and activism?

(3) How did nurse-midwives shape the women’s health movement going on at the time? In asking this question, the study focuses on how the midwives associated with each organization navigated the social and political implications of their own actions.

(4) To what extent did the nature of the relationships within the nurses’ collaborative networks shape their success and advocacy for maternal and infant care?

Very little is known about nursing’s contributions to the larger women’s health movement and how nurses navigated the tapestry of post-civil rights movements and concerns. This dissertation unpacks the work of midwives who can be understood as representatives of nursing and women’s health through their work with women and communities. Their work can also be located within a fertile rights advocacy sociopolitical context: one that existed in tension with various sources of power. A historical understanding of successful models of nursing advocacy and mobilization will add to theoretical discussions of what patient advocacy means within the roles of the nurse and the client/community. In addition, data will explore nurses as powerful actors within this time and movement, thus giving them voice and identity during this pivotal period of women’s health history. Nurses have not been identified as playing an important role in the myriad of post civil-rights voices and concerns. This study will help locate nurses during this pivotal era of history. In addition, as the role of advanced practice nurses expands in contemporary times, this study will shed an important guiding light onto how nurse-midwives navigated the highly sociopolitical context in the not so distant past.
The MCC in Philadelphia and the MCA in New York City share a legacy as two organizations representative of advocacy work for women by midwives through collaborative relationships with the surrounding community. The two organizations geographically represent two large northeast urban cities, both of which struggled with enduring health issues affecting their most vulnerable women and children during the 1970s to 1990. Both of these organizations established nurse-run birthing centers that offered childbirth as well as other types of services such as pediatric clinics that focused on maintaining health in their communities. However, both have significantly different histories. The MCC represents a 1980s grassroots response to enduring infant mortality and health inequities in the city of Philadelphia. On the other hand, the MCA collaborated with the city as a response to health concerns that began during turn of the century New York City.

This research examines how both the MCC and MCA evolved under the leadership of their respective nurse midwives and other activists within their unique sociopolitical contexts. Critical to this examination is gaining an understanding of the collaborative processes that nurse midwives pursued in their individual contexts. An important part of understanding MCC’s and MCA’s collaborative processes is the universal idea of people with various compatible personalities working together. Questions such as how diverse groups, from city policy-makers to midwives to philanthropists to women themselves worked together to move the organizations forward as well as how the activists negotiated moments or periods of discord will be addressed.

By using both the MCC and the MCA as case studies, advocacy work by nurses is examined. Operating within the framework of the women’s health movement, I show
how nurses mobilized toward the ideals of this movement with women of various races and classes. The post-civil rights sociopolitical context of nurses’ work is nested within the intersection of several important movements and ideologies. These include the growing number of black women’s organizations formed in order to give collective voice to their racial and health concerns; a growing Black and Latino nationalist movement as evidenced by the birth of the Black Panthers and the Young Lords; as well as a looming and growing sense of medical mistrust by minorities. As a result, nurse midwives and their collaborative partners utilized ideas and innovations to mobilize and advocate for low-income women within a political landscape wrought with a multiplicity of power struggles and tensions.

Definitions of Terms

Several concepts in this study relate to the work of the midwives and their communities. A nurse-midwife is a professionally educated practitioner who was first trained as a registered nurse and then received further nationally accredited education in midwifery. Advocacy is defined as the public support for or recommendation of a particular cause or policy.8 Activism is defined as the policy or action of using vigorous campaigning to bring about political or social change.9 Social justice refers to the concept of a society in which justice is achieved in every aspect of society.10 Each of these important concepts gains further distinction and depth as they are applied to place and

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10 Ibid.
time.\textsuperscript{11} Therefore, it is important to consider that not all midwives work for social justice or within low-income communities. In addition, advocacy, activism, and social justice are socially constructed concepts that generally converge within a space known as a social movement. Social movements are defined as spaces in which beliefs are formed and solidified, not simply reflections of preexisting beliefs, preferences, or grievances.\textsuperscript{12}

**Social Movement Literature**

Individual beliefs do not logically and causally precede social movement participation. Many activists who join a social movement are at best ambivalent in their beliefs. In addition, their beliefs change in the process of becoming mobilized. Ziad Munson proposes a stream metaphor as a useful device to describe the subsets of social movements as fluid and unfixed energies. The composition of these subsets is subject to change as individuals, organizations, and surrounding environments change and intersect. The streams metaphor serves as an apt descriptor of the women’s health activism for actors in this dissertation. It also allows for the important consideration of the complicated intersection of the multiplicity of voices and movements surrounding this highly charged sociopolitical context.\textsuperscript{13}

When conceptualizing advocacy and activism by women for women, gender, class, and race come to the forefront. In the literature, there exists a wide range of groups with different levels of social class as well as groups that are more homogenous. Nancy Naples’ research speaks to a more homogenous group of community activism in which

\textsuperscript{11} Ibid.
\textsuperscript{13} Ibid.
the women come from very similar class backgrounds. Naples’ work effectively situates community activism by low-income women for low-income women, and demonstrates the diversity of women’s struggles involving violence, homophobia, housing, civil rights, economic security, educational equity, and environmental justice. Naples’ work revealed that women from the same communities were able to transcend their issues in a more empowering manner than had they received help from outside their own communities. In other words, the networks of support these women built proved to be more beneficial in the long run to their local communities than any other type of intervention.14

There are also examples of a seemingly more hierarchical yet nonetheless effective type of advocacy and activism in the literature. Members of this type of collaborative consist of various social classes, yet they draw from each other’s experiences in order to view both the problems and the solutions through shared multiple lenses. As opposed to a hierarchical style of leadership and decision-making, this style of collaboration places a collective value on all members’ contributions and perspectives, regardless of race and class.15

Andrew Barlow speaks to this type of collaboration and the power of cross class community activism. In his work, Barlow shares the voices of participants in the collaborations between community based activists, academia, and lawyers. The collaborative groups identify five guiding principles to their work consisting of (1) a shared commitment to democracy, (2) a shared understanding that everyone, not just

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14 Nancy Naples, ed., Community Activism and Feminist Politics (New York: Routledge, 1998). In addition to Naples’ work, Annelise Orleck’s Storming Caesar’s Palace: How Black Mothers Fought Their Own War on Poverty highlights the life of Ruby Duncan, a hotel maid, who organized and built community based services for her community for over twenty years outside of Las Vegas’ lavish Strip.

15 Naples, Community Activism and Feminist Politics.
experts, is capable of developing ideas, (3) a shared understanding that people’s ideas are shaped by their location in society, (4) a shared understanding of the dimension of power in intellectual work and its mobilization by those who are marginalized. This is vital to the advancement of ideas that flow from their experience. (5) Finally, the last principal is a shared belief that professionals can and do play important roles in facilitating the emergence of ideas from marginalized communities, and the mobilization of community based power is vital to make these ideas historically significant.16

As I discuss in the following chapters, nurse-midwives’ work occurred within a sociopolitical context that housed highly significant themes occurring within the 1960s, 1970s, and 1980s. These themes, propelled by a powerful civil rights’ momentum, include the growing women’s health movement, an increase in health activism by Black, Latino, and other nationalist movements, and a powerful push towards the reconceptualization of health as a civil right. As Munson’s social movement streams metaphor suggests, these voices not only collided but also created a complex intersection of lenses through which health would be considered.

**Contributions of This Study**

Each of the studies cited above give attention to grassroots activism for women’s health at various levels. They show that activism from women, civil rights leaders, and community health workers fought for changes in women’s health. This dissertation adds to the literature by positioning how advocacy for women during the women’s health movement might be conceptualized if nurses and nursing history was used as the

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analytical lens. Despite feminism’s historical distaste for the profession of nursing and the popular notion of its relentless subordination to physicians, the fact remains that there are a number of nurse activists and nurse feminists waiting to have their stories told. By locating and including nursing, specifically nurse midwives, into the complicated historical landscape of activism and advocacy, this research will reorganize and broaden our view of women’s health and the organizations created to support it.

In the literature, nursing advocacy is generally defined as a relatively streamlined process that holds significant importance in the nursing profession. Janie B. Butts and Karen L. Rich explain that the nurse acting from a point of patient advocacy must try to “identify unmet patient needs and then follow up to address the needs appropriately.” They go on to further explain that when nurses enter the nursing profession, they are in essence agreeing to a social contract with the public as outlined in Nursing’s Social

17 Ellen Baer wrote a highly effective critique of the feminist stance on nursing in a New York Times Op-Ed entitled, “The Feminist Disdain for Nursing.” Baer argues that despite the “terrible paradox of feminism, which glorifies women who emulate masculine behavior while virtually ignoring women who choose traditional female roles and careers,” nurses can be feminists while at the same time perform their caring roles. Baer asserts that professional nursing requires “brains, education, judgment, fortitude, inventiveness, split-second decision making, interpersonal competence and day after day determination.” She ends with a call to feminists and nurses stating, “feminism will have succeeded not only when women have equal access to all fields but when traditional female professions like nursing gain the high value and solid social respect they deserve.” See Ellen Baer, “The Feminist Disdain for Nursing” The New York Times, 23 February 1991, 25.

18 Nurse historians Julie Fairman and Patricia D’Antonio asked this question in terms of medical history as conceptualized with nurses and nursing history as the analytical lens. See Julie Fairman and Patricia D’Antonio, “Reimagining Nursing’s Place in the History of Clinical Practice,” Journal of the History of Medicine and Allied Sciences 63, no. 4 (2008).


20 Janie B. Butts and Karen L. Rich, Nursing Ethics Across the Curriculum and Into Practice (Sudbury: Jones and Bartlett, 2008), 56.
Policy Statement.\textsuperscript{21} Nurses are also bound to the Code of Ethics for Nurses.\textsuperscript{22} For example, a statement contained in the Social Policy Statement places the concept of advocacy in a position of centrality:

Patients give nurses permission to enter their lives and share their most intimate life experiences. Registered nurses remain in nursing to promote, advocate for, and strive to protect the health, safety, and rights of those patients, families, communities, and populations. Registered nurses value their role as advocates in dealing with barriers encountered in obtaining health care. Similarly, society values nursing care that resolves problems, or manages health-promoting behaviors.\textsuperscript{23}

When the lens is shifted to include the various contexts representative of nurses’ work, the essence of nursing advocacy also shifts. For example, Sandra Henry Kosik, a public health nurse writes of her daily professional life in the 1970s as an intense struggle to advocate for her patients.\textsuperscript{24} Kosik explains that working in Detroit’s low-income communities requires a version of advocacy that goes much further than textbook definitions. This advocacy involves a “deeper commitment” than hospital nursing or working within middle to upper class communities. In her words, “seeing that the patient knows what to expect; what is his right to have; and then displaying the courage to see that our system does not prevent his getting it.” Yet, Kosik also relates that the profession of nursing has been hesitant to step outside of its boundaries and take on a deeper type of

\textsuperscript{24} Sandra Henry Kosik, “Patient Advocacy or Fighting the System,” American Journal of Nursing 72, no. 4 (1972), 694-698.
advocacy. Kosik is sharing her rights perspective from her work related context. 25 My research helps to place nurses who take advocacy into a “deeper commitment” into our histories of nursing, feminism, and women’s health.26

Despite Kosik’s story, much of the widely acclaimed literature covering the women’s health movement either completely leaves nurses out of the narrative or downplays their roles. Sandra Morgen’s, Into Our Own Hands: The Women’s Health Movement gives a fascinating account of how the 1970s witnessed major transformations in the realm of women’s health at the hands of feminist coalitions.27 However, the term, “nurse” does not appear in her text, not even in the index. In addition, Carol Weisman’s work, Women’s Health Care: Activist Traditions and Institutional Change tangentially mentions nurses. In her section titled, “Women and Health Care Delivery: Providers and Organizations,” she writes that the contributions of advanced practice nurses (particularly nurse practitioners and certified nurse-midwives) to primary care “has not been a major one.”28 In addition, a nurse researcher whose area of focus is nursing advocacy argued that nurses tend “not to get involved with consumer groups or align themselves with their aims.”29 This dissertation addresses these inconsistencies.

27 Sandra Morgen, Into Our Own Hands: The Women’s Health Movement in the United States (New Brunswick: Rutgers, 2002)
Despite the relative absence of nursing advocacy in written histories of the women’s health movement, there are accounts that do bring these stories to the forefront. Susan Gelfand Malka, a nurse and historian, mentions the activities of nurses, especially in the 1970s as nurses moved forward with funding in community health.\(^{30}\) Many nurses, she notes, opened community health clinics associated with universities to underserved populations. Julie Fairman’s work speaks to nurse practitioners who entered the market of health care and soon found themselves negotiating their roles with physicians.\(^{31}\) In addition, Meryn Stuart challenges historians of nursing to consider the early to late twentieth century nurse advocate as “fervent activist and radical.”\(^{32}\) The historical research I am proposing will add to these accounts. By telling the story through the voices of the midwives, the study will add to nurses’ interpretations of their advocacy work.\(^{33}\) This in turn, will add richness and depth to understandings of nurse-led advocacy and activism.

This research examines the multiple negotiations assumed by midwives and others in caring for, advocating for, and working with diverse women, thus adding to broader scholarship that locates women’s advocacy in an arena that crosses race, gender, and class boundaries. It specifically locates nurse midwives at the center of this intersectional work. By focusing on the key role of nurse midwives, it also will show the

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\(^{33}\) Sociologist, Amy Blackstone studied women volunteers from the Susan G. Komen Breast Cancer Foundation in an effort to understand participants’ perceptions of their advocacy and activism work. She found that caring and “being political” are often conceived as distinct and opposing ways of being, especially for women activists. See Amy Blackstone, “It’s Just About Being Fair”: Activism and the Politics of Volunteering in the Breast Cancer Movement,” *Gender & Society*, 18, no. 3 (2004).
importance of grassroots social movements, or change from below in nursing history. Finally, an historical understanding of successful models of nursing advocacy for women and children is vital as the U.S. still struggles with high rates of infant mortality in its minority populations.

**Methods and Archival Sources**

This project uses established historical methods to identify appropriate sources and evaluate and interpret data from these sources within the broader framework of historiographical literature. It uses a social history framework, with case studies and oral histories, to describe and evaluate the players involved in women’s health activism in Philadelphia and New York City in the 1970s to 1990s.

Primary sources include documents, notes, personal letters, and other archival sources in the collections listed below. Other sources utilized for this project are primary sources from advocacy organizations and numerous secondary sources in the fields of civil rights activism, social justice, women’s health, social change and scholarship dedicated to the muted voices of women working behind the scenes in the civil rights movement in addition to works that address the power of ordinary people in social movements.

Secondary sources include a large body of scholarship on the civil rights movement, the feminist movement, the women’s health movement, and scholarship considering health care as a civil right. Nursing scholarship on advocacy is utilized in order to gain an idea of how the profession of nursing has located itself in this concept.

IRB approval for oral histories has been obtained.
1. Van Pelt Rare Book and Manuscript Library, University of Pennsylvania- The Maternity Care Coalition (MCC) records contain the institutional records of the Philadelphia based community health organization and span the years of 1965 to 2009. Seven Philadelphia area organizations, composed of healthcare professionals and welfare and women’s rights groups, joined together to start MCC.

2. Augustus C. Long Health Sciences Library, Columbia University- The Maternity Center Association (MCA), known since 2005 as Childbirth Connection, has played a key role in improving maternal health and prenatal care in the United States. Its records reflect many of the major trends in 20th century American public health, nursing, childbirth, and philanthropy.

3. Temple Urban Archives, Temple University- CHOICE- In 1970, the Philadelphia Clergy Consultation Service (CCS) began training women from the Pennsylvania Abortion Rights Association (PARA) to provide pregnancy options counseling. In 1971, these women founded CHOICE (an acronym that originally stood for Concern for Health Options, Information, Care and Education, and later stood on its own). In 1973 CHOICE was granted non-profit status. The organization has received funding from a number of sources, including MSP (Maternity Services Program, Philadelphia Department of Public Health; formerly known as MIC, Maternal and Infant Care Program), the Family Planning Council of Southeastern Pennsylvania, Women’s Way, and AACO (AIDS Activities Coordinating Office, Philadelphia Department of Health).
Limitations

This research relies heavily on oral history interviews, which have some limitations. They are about memories; while the events are true to the person recalling the history in their particular time, these events may be recalled in such a way that reflect how the interviewee wants the events to be remembered. Problems also include memory loss since the oral history was obtained some years later. However, it is just as important to focus on what the participants choose to remember and why they make those choices. In order to account for reliability and validity, I have utilized both primary and secondary sources to validate content.
Chapter Two

A Review of the Women’s Health Movement
This chapter situates the grassroots activism of the type by MCC and MCA in the 1970s and 1980s within the larger significant movement for changes in health care for women in other parts of the country. The women’s health movement came into its own under the wings of the feminist movement and the pivotal era of 1960s’ protests. The 1960s, with its iconic images and wide ranging representations of protest and dissatisfaction towards almost every public and private facet of American society, played a critical role in understanding the power, complexities, and tensions of the women’s health movement. In particular, the decade set a foundational stage for the highly visible, powerful, and enduring intersections of race, class, and gender.

As women called for equality, democracy, and the right to claim ownership of their bodies, their health and its management became an important focal point. Despite its outward appearance of purpose, that of benefitting women, the women’s health movement was fractured along its way both in purpose and composition. In spite of successfully building on the momentum of the civil rights movement, white feminists had to confront a series of strong backlashes from minority and working class women who clearly voiced their perceived lack of representation within the larger movement. Women of various color and class expressed very different kinds of concerns than their white, middle to upper class sisters. Thus, this chapter will also describe other women’s voices and concerns that birthed a movement within a movement as Black, Latina, and other
representatives of women came forward with their stories of societal discrimination and displacement. Described as a “messy multiplicity,” this period witnessed Black feminists, middle class white women, and radical youth intersecting with each other as well as a newly developing political Right.34

Before the women’s health movement took center stage, feminists were primarily concerned with achieving a sense of equality with the opposite sex across political, social, and labor issues. Black feminists, on the other hand, focused on articulating their race, gender, and class identities as interconnected. Emerging from the civil rights movement cycle of protest, but also at the same time as the predominantly white women’s movement, Black feminists attempted to simultaneously define a collective identity and establish organizations that encompassed their rights as both Blacks and women.35 This emergence of Black feminism with its myriad of collective voices served as an important seed for Black women and other women on color in the larger women’s health movement.

The 1960s’ turbulence also witnessed a new generation of Americans expressing their dismay that the wealthiest, most powerful nation in the world could not adequately provide for its own citizens and sought other solutions. Michael Harrington’s *The Other America* reminded a generation reared in relative prosperity of the hidden poverty that still crippled the lives of many Americans. Young Black southern civil rights workers

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34 Nancy A. Hewitt argues that the use of the wave metaphor tends to portray concrete start and end points giving the false idea that the feminist movement had distinct periods. Hewitt challenges her readers to conceptualize this time as radio waves with their different frequencies. As movements grow louder then fade out, they parallel the diverse frequencies of radio waves. Hewitt contends this period was anything but categorical, but rather a “messy multiplicity” of intersectionality. Nancy A. Hewitt, ed., *No Permanent Waves: Recasting Histories of U.S. Feminism* (New Brunswick: Rutgers, 2010) 7.

founded the Student Nonviolent Coordinating Committee, whose goal was to create a “beloved community” while working to end segregation through nonviolence. Two years later, New Left activists on college campuses launched Students for a Democratic Society (SDS), committing themselves to persuading their country to live up to its democratic ideals. In 1968, radical feminists staged a series of dramatic protests culminating with the crowning of a sheep at the annual Miss America pageant to protest the sexual objectification of women. 36 During this period, few issues were left unexplored, and no political structure went unchallenged. By the end of the period, a postwar confidence was replaced with cynicism and doubt. This negative societal shift was also directed at the medical profession.

Medical care became one of the nation’s largest industries in post-World War II America.37 Yet, by the year 1970, medicine along with other social institutions, suffered a “stunning loss of confidence.”38 Accounts of patient experimentation and unethical treatment challenged the belief that doctors held the patient’s best interests in mind. Patient rights became a movement unto itself as particular consumer groups including the aged, African Americans, gays and lesbians, as well as women argued for their own bill of rights. 39

In the 1970s, as women became more vocal, they shifted their sights to include health as a measure of inequity and injustice. The definition of women’s health, the question of who should control it, and how to own it became central to the essence of this

38 Ibid, 379.
movement. Harnessing their collective strength in parallel fashion to U.S. civil rights activists, feminists presented an organized challenge to powerful groups such as the medical profession and hospital administrators.

Women began teaching each other about their bodies and challenging their doctors’ decisions in terms of their healthcare, especially in the realm of reproduction. Pregnancy and childbirth were considered important feminist life events that did not require unnecessary medical interventions. Rejecting the role of passive patient, women learned to be assertive, ask tough questions, do their own research, insist on certain tests, refuse others, and demand that doctors take their ailments seriously. Thus, women’s health grassroots activism became not just a movement but also a discourse.

In a parallel fashion to their interpretation of the overall women’s movement, women of color challenged normative definitions of the term reproductive rights largely through their ambivalence over abortion rights. As Angela Davis contends, white activists frequently overlooked ideological underpinnings of the reproductive rights movement. Before Roe v. Wade, most minority women who sought abortion services

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40 The Boston Women’s Health Book Collective’s (BWHBC) work has become foundational to any story of the women’s health movement. In 1973, they published Our Bodies Ourselves, which started as a small discussion group on women, and their bodies. The BWHBC began as a middle-class group of white women talking about their individual concerns and complaints over their own experiences with physicians, much of which was hierarchical and patriarchal in nature.


42 For more discussion on the importance of the discourse of women’s health, see Nancy Tomes, “Patients or Health-Care Consumers? Why the History of Contested Terms Matters,” in History & Health Policy in the United States, eds. Rosemary Stevens, Charles E. Rosenberg, and Lawton Burns (New Brunswick: Rutgers University Press, 2006).

43 Angela Y. Davis, Women, Race, and Class (New York: Vintage Books, 1983), 202. In addition to Davis, Dorothy Roberts’ Killing the Black Body: Race, Reproduction, and the Meaning of Liberty also grapples with a historical understanding of race and reproduction. Roberts’ three central themes are the 1) regulation of Black women’s reproductive decisions as a central aspect of racial oppression in America; 2) control of Black women’s reproductive rights, which has shaped the meaning of reproductive liberty in America; and 3) reconsideration of the meaning of reproductive liberty to take into account its relationship to racial
were forced to do so with back-room abortionists. In fact, several years before the legalization of abortion, New York City witnessed 80 percent of its deaths from botched abortions as belonging to Black and Puerto Rican women. Davis argues that these women were not so much pro-abortion as they were pro-reproductive rights. In addition, many of the minority women who sought abortions were forced to do so because of poor health and living conditions as opposed to their desire to be free of their pregnancy. Through an appreciation of the socially constructed nature of reproductive rights, activists were challenged to gain an important understanding of their various sisters in the cause. This understanding was not always operationalized.

Until the exposure of reproductive rights violations, it was hard for feminists to approach mutual understandings and effective collaborations towards a fully representative reproductive rights platform. Elena R. Gutierrez speaks to this exposure in her challenge to the stereotype of women of Mexican origin as hyper-breeders. By adopting a social constructivist approach to the analysis, Gutierrez turns the cameras around to focus on the institutions that claim ownership of the “problem” of the fertility of Mexican women: demographers, medical professionals, population policy makers, and Chicana feminists.

Together these activists challenged how medicine and society viewed the health of women representative of multiple races and classes. By the 1970s, as Dan Berger argues, social movements experienced both repression as well as periods of oppression. Both Davis and Roberts argue that the regulation of Black women’s reproductive decisions is rooted in a system of slavery that valued fertility because it benefitted the slave owner financially.

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44 Davis, *Women, Race, and Class.*

experimentation and expansion. The pioneering work of women’s groups in the 1960s eventually created a constituency for and shaped the agenda of the National Women’s Health Network, formed in 1975 as a national organization dedicated to advancing the health of women of all classes and races through authoritative watchdog organizations, evaluating treatments, research trials, and government policies. At the same time, these same women’s health activists also pushed the controversial borderlands of women’s health into public visibility. Issues such as rape, women prisoners, women and mental health, as well as the legalization of prostitution were ideologically challenged in urban cities such as Philadelphia for desired reform. As Berger asserts, the radicals in the 1970s were committed to trying new things in which resolution was sought through circumventing criminal justice systems and police.

**Health Care as a Civil Right**

*Reproductive Rights*

The notion of health care as a basic civil right is a common thematic component of the philosophical foundation surrounding the MCC and MCA work of nurses, communities of marginalized women, and their collaborative organizations. This included reproductive rights. Histories of forced sterilizations, a part of the legacy of the eugenics movement and its enduring influence on mid-twentieth century birth control policies and actions, and back-room abortions riddled the U.S. landscape in the middle to late twentieth century. As Rebecca Kluchin argues, the mid to late 1970s witnessed white

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47 Women’s Health Concerns Committee, MS 588. Box 23, Folder 328 Women’s Health Collection, Annenberg Rare Book & Manuscript Library, University of Pennsylvania, Pennsylvania (hereafter cited as ARBML).

women struggling to gain access to sterilization while overturning age/parity spousal
consent and other restrictive policies. This led many from this particular group to define
reproductive freedom as access to reproductive health services. On the other hand, during
this same timeframe, women of low resources, especially women of color, found
themselves the targets of coercive sterilization procedures.49

When new organizations in this later period formed to initiate policies geared to
end sterilization abuse, fractures within several of the pro-reproductive choice feminist
organizations occurred. Kluchin details these events starting with the Health and Hospital
Corporation (HHC) Advisory Committee on Sterilization. The HHC proposed a series of
guidelines designed to eliminate sterilization abuse in New York City hospitals. Advisory
Committee members faced fierce contestation from physicians, Planned Parenthood, and
the Association for Voluntary Sterilization (AVS). Kluchin contends the most surprising
opposition came from white liberal feminist organizations like the National Organization
for Women and the National Abortion Rights Action League. These groups opposed
forced sterilization, but disagreed to the strategies ending abuse proposed by HHC.
Specifically, they objected to the mandatory wait period HHC proposed between consent
and surgery, designed to prevent coercion during a woman’s labor and delivery.50 The
HHC Advisory Committee members acknowledged the wait period as possibly
interfering with a woman’s desire to obtain sterilization “on demand.” But, they argued, a
woman’s right to be free from coercive sterilization should ethically weigh more than a
woman’s right to have unrestricted access to sterilization services. Kluchin maintains the

49 Rebecca M. Kluchin, Fit to be Tied: Sterilization and Reproductive Rights in America, 1950-1980 (New
50 Ibid.
foundational conflict lay within the premise that in order to protect one group of women, another group had to endure some restrictions on their access. Kluchin argues that liberal feminists, family planners, and New York doctors cast themselves as guardians of poor women’s reproductive rights but did so by advancing a middle-class white definition of reproductive freedom that was premised upon preserving on-demand access to reproductive procedures.51

**Negotiations of Health Care Rights**

The nurse-midwives featured in this study, especially those who worked in the MCC, were also a part of the medical community’s desire to provide health care to marginalized communities of women and their families. There is a legacy of medical communities’ response to health care inequity as witnessed by the Medical Committee for Human Rights (MCHR). Indeed, one of the significant relationships between women activists in the Philadelphia’s MCC and physicians occurred between them and Dr. Walter Lear, a founding member of the MCHR. The MCHR began in 1964 as an ad hoc support group for volunteers and veteran activists.52 It became an organization of health professionals with chapters in major cities across the country. The MCHR provided medical care for civil rights workers in the South, desegregated area hospitals, and picketed conventions of the American Medical Association (AMA) to protest the AMA’s refusal to require its southern affiliates to admit Black physicians. In the late 1960s and early 1970s, MCHR moved on to support many of the causes of the New Left such as opposition to the war in Vietnam. Its local chapters developed task forces to deal with

51 Kluchin, *Fit to be Tied.*

problems ranging from prison reform to occupational health and safety. The organization’s founders were primarily established Jewish physicians, the children of Eastern European immigrants. Born and raised in New York City, they were active in groups associated with what would later be called the Old Left. Several of them had been or still were members of the Communist Party.

The MCHR’s first three chairpersons were Black, but the Medical Committee was essentially a white organization. Dittmer contends that the successful efforts of these privileged, older white professionals such as Lear to reach out to dedicated, angry young Black militants adds a new dimension to understanding the struggle for civil rights in the South. By 1965, major currents in the civil rights movement were radically changing. Black Power was gaining momentum, as was a strong anti-war sentiment from some of the MCHR physicians. It was the desire for an anti-war resolution and stance that some of the MCHR physicians wanted for the organization. This issue would serve as one of the most enduring fractures within the organization.

Race became another stress fracture for MCHR as the civil rights movement festered racial tensions between northern white women working with southern Black activists. When one of the major civil rights organizers wrote a paper detailing the stressors of these new working relationships between gender and race, several of the MCHR nurses felt their time in the organization was dwindling. Still, Dittmer argues that MCHR paved much of the way in creating the climate that made the health center

53 Ibid.
54 Dittmer’s work closely examines several nurses involved with MCHR during this period. During the highly contentious period occurring shortly before the decline of the organization, it was the nurses who maintained services to the civil rights workers and communities and kept several centers open after a majority of the MCHR physicians had left.
55 Dittmer, The Good Doctors.
movement possible. Without its Freedom Summer presence in Mississippi and other clinics that served as models in the South, Dittmer contends it is questionable whether the community health center concept would have emerged when it did.\textsuperscript{56}

\textit{A Community Approach}

Bonnie Lefkowitz closely examines the history of five community health centers whose leadership and histories witnessed enduring positive outcomes in the communities they served. Lefkowitz contends that community health centers owe their origins to national leadership’s new discoveries on poverty and powerlessness. Organizations such as Mobilization for Youth on New York’s Lower East Side were implementing something called “opportunity theory” and were beginning to involve residents in the area. President John F. Kennedy became quickly convinced that one of the fundamental keys to overcoming poverty and crime was to provide community based opportunities for youth. This became the impetus for a national community action program that was drafted by legislation and was known as the Economic Opportunity Act.\textsuperscript{57}

Lefkowitz follows several representative community health centers in Mississippi, Massachusetts, South Carolina, New York, and Texas. Through various sociopolitical contexts, Lefkowitz chronicles their roots in civil rights and social justice as well as the conditions and cultures in the diverse communities, the problems faced, and their adaptations to changing times. Each center interacted with health care institutions, and other safety net programs, levels of insurance coverage, and state/local support. Each center found its way from near total dependence on federal grants and providers to a fully

\textsuperscript{56} Ibid.

credited staff and sophistication, Lefkowitz argues, that rivaled most large health care organizations with multiple revenue sources.\(^{58}\)

The seeds for the redefinition of health were planted in Mississippi. In 1960, the state had the nation’s highest infant mortality rates at 54.4 deaths per 1000 births. This rate was twice the rate for whites and 25 percent higher than the national Black infant mortality rate. A 1969 article in the *Wall Street Journal*, entitled “The Ailing Poor: Medical Team Combats Negroes’ Dismal Health in Mississippi Delta” chronicled the work of the Medical Committee for Human Rights (MCHR) and others who descended into Mississippi during Freedom Summer. Health, these activists discovered, was not limited to the repair of the physical body. Health took on new meanings of prevention, access, and community based caring. Nurses and others in the MCC and MCA also embraced this broader consideration of health and community.

*Transforming Knowledge: The Boston Women’s Health Book Collective*

The first and most comprehensive book to provide knowledge about women’s health and their sexuality was the Boston Women’s Health Book Collective’s (BWHBC) *Our Bodies Ourselves*. In the first edition, the Collective asked, “What are our bodies? First, they are us. We do not inhabit them, we are them.”\(^{59}\) In the 1970s, this claim was controversial as feminists debated over the theoretical position of the female body. “Difference” feminists, such as the authors of *Our Bodies, Ourselves*, placed the female body at the center of their identity. By contrast, “equality” feminists sought to displace the biological barrier by deemphasizing the body. Wendy Kline reminds the reader that

\(^{58}\) Ibid.

the ideological divide between “difference” and “equality” feminists had profound implications for women’s health and feminism in the late twentieth century. Indeed, historically, claims of difference between men and women were used to reinforce a gender hierarchy, thereby marginalizing women.\(^{60}\)

Not all feminists embraced the notion that female biologic difference could be used to fight oppression. As Kline argues, the key to comprehending this “feminist paradox” lies in understanding the historical relationship between scientific knowledge, women’s bodies, and medical practice.\(^{61}\) The late nineteenth century ushered in a new paradigm of experimental science that privileged laboratory research over clinical observation. Supporters of the new laboratory science praised it as more rational, detached and objective. Critics, such as Dr. Elizabeth Blackwell, viewed it as flawed and potentially placing the patient’s subjectivity as lesser than that of science. This new experimental science dismissed empathy and nurturing as distinctly feminine and as bad science, replacing these approaches with objectivity and clinical detachment – both distinctly masculine.\(^{62}\)

The 1970s feminists continued the legacy of the difference conversation. Feminist poet Adrienne Rich argued in 1976, “We need to imagine a world in which every woman is the presiding genius of her own body. In such a world, women will truly create new life, bringing forth not only children (if and as we choose) but the visions, and the thinking necessary to sustain, console, and alter human existence – a new relationship to

\(^{60}\) Ibid.
\(^{61}\) Ibid, 1.
\(^{62}\) Ibid.
the universe."63 This argument positioned women’s bodies at the center of women’s liberation. Women would never attain equal status, difference feminists argued, without the authority over and knowledge of their own bodies. Thinking from within the body as opposed to around it, became a central component to female empowerment. In addition, these feminists believed women should have access to information about their bodies and they should also help create this knowledge.

According to Kline, the authors of *Our Bodies, Ourselves* felt accountable to their readership and welcomed their audience into the conversation of women’s health.64 By including many voices and stories of women and their health, the BWHBC not only contributed to the feminist notion of consciousness raising but also to the process of knowledge construction. Susan Bell, one author of the chapter focusing on birth control, expressed her challenge as “to see from and speak to the perspectives of teenagers, single women, women of color, poor women, women with disabilities, and women without health insurance without falling into the trap of believing I could be simultaneously in all or wholly in any, of these subjugated positions.”65 The representation of diverse feminist perspectives was achieved by not claiming to represent all women but through the inclusion of their stories, thereby speaking to a more diverse body of women.

**Dissatisfaction with Obstetric and Gynecologic Services**

Sheryl Ruzek notes that in the 1970s, there was already a history of widespread dissatisfaction with conventional obstetric and gynecologic services, “even among the

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64 Kline, *Bodies of Knowledge*, 25. See also Morgen, *Into Our Own Hand*. Morgen refers to the BWHBC’s *Our Bodies Ourselves* as print based consciousness raising.
women not actively involved in either the women’s health movement or the larger feminist movement.”

The acts of expressing that dissatisfaction were as varied as the women behind them. On April 7, 1971, at Every Woman’s Bookstore in Los Angeles, Carol Downer inserted a speculum into her vagina and invited other women to observe her cervix. Five months later, a similar demonstration took place at a national meeting of the National Organization of Women (NOW) in Los Angeles. Within a year of Downer’s first public self-exam, over two thousand women had attended self-help women’s clinics. Many credit Downer’s actions as the formal start of the self-help gynecology and other women’s body issues movement. Self-examination and self-help gynecology were revolutionary concepts. Women were now able to reclaim parts of themselves controlled by male professionals. Downer’s self-observation of her cervix became the banner for women to reclaim the right to become acquainted with their own vaginas: a rite, until that time, had been formally and solely owned by the male dominated field of gynecology.

Women learned to detect signs of common gynecological disorders such as the detection of yeast infections. They also learned natural remedies for certain disorders such as yogurt, applied directly to the cervix to relieve monilia, commonly known as the yeast infection.

Ruzek argues that what most upset the medical establishment was another form of self-help procedure known as menstrual extraction invented by Downer and Lorraine Rothman in their Feminist Women’s Health Clinic. Downer and Rothman developed

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67 Ibid.
68 Ibid. Also known as menstrual induction, menstrual regulation, or endometrial aspiration, the procedure was developed even before the onset of self-examination. The technology making menstrual extraction possible was Rothman’s Del-’Em jar- a syringe connected to an airtight vacuum-controlled bottle. This
this procedure so that women could regulate their menstrual cycles as they wished. During this time, physicians were performing a similar technique to remove uterine contents in the legally “gray area” between the time a woman missed her period and the time pregnancy could be confirmed. For obvious political and legal reasons, Downer and Rothman never publically presented menstrual extraction as an abortion technique. Instead, they advertised it as a method of reducing the length and discomfort associated with menstrual periods. Despite its platform as an important move towards a woman’s control of her own body, many feminists were not comfortable with the menstrual extraction procedure resting in the hands of non-medicals.

The medical community stood fairly united in its stance that no layperson should be performing menstrual extractions or any other procedure that could conceivably fall under the realm of medical authority. By the summer of 1972, the Feminist Women’s Health Clinic in Los Angeles had been subject to undercover surveillance for six months. On September 20, 1972, Los Angeles police arrested Downer for practicing medicine without a license. She had helped a woman insert a speculum and had suggested yogurt for a yeast infection. Although a jury acquitted her of all charges two months later, the incident outraged local feminists.69 Downer chose to stand trial with the purpose of

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69 Rosen, *The World Split Open*, 176-177. Within a year after Downer began publicizing self-examination, over 2,000 women had attended clinics and demonstrations. By 1975, self-examination had been demonstrated not only in the United States but also in Canada, Mexico, England, France, Germany, Italy, Northern Ireland, Belgium, Denmark, West Berlin, and New Zealand. In the United States, self-help groups and women’s gynecology clinics operated in most major metropolitan cities as well as some smaller communities. The community of self-help published a monthly newsletter called *The Monthly Extract*. It was the first health movement communications network through which women learned of each other’s activities. The informal newsletter format—short articles, letters from readers, reprints of newspaper
bringing national attention to the feminist self-help cause. Comparisons were made between the Los Angeles feminists and early birth control crusaders Margaret Sanger and her sister, Ethel Byre. All three women were willing to go to jail for their cause.\(^70\)

Challenging medical authority quickly became a tactical cornerstone of the women’s health movement. In 1973, feminist authors Barbara Ehrenreich and Deirdre English wrote a 45-page pamphlet on the history of women healers and the entrance of the male physician. Noted as a beginning look into the suppression of female healers by the medical establishment, *Witches, Midwives, and Nurses* provided a call to action for those interested in the struggle of midwives and other female healers.\(^71\) Two years later, a revealing look into the pregnant woman in America and the falsehoods that confronted her once inside the hospital was published. Suzanne Arms’ *Immaculate Deception* joined the growing list of critical analyses of the American way of birth controlled by the medical establishment. In true feminist fashion of the time, Arms shared her disappointing experience with medically supervised, hospital childbirth with the reader.\(^72\) At a time when feminists were writing about topics such as control and power in the birthplace, this was especially significant.

Feminist researchers also recognized that where medicine was practiced on a fee-for-service basis, surgery rates were higher than in countries with socialized medicine. In particular, Barbara found that many of the gynecologic surgeries were suspected to be clippings, and announcements of conferences and other events encouraged women to share ideas and exchange information.

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\(^70\) The FWHC’s monthly newsletter: *The Monthly Extract* compared Downer to the suffragettes as well as Margaret Sanger and Ethel Byre. The newsletter proclaimed Downer as willing to go to jail and follow in the footsteps of Sanger and others.


unnecessary. Of the hysterectomy cases she audited, a review of all records, including the operative report and pathology findings, led the auditors to conclude that one-third of the women were operated on unnecessarily; another 10 percent were of questionable necessity.73

The National Women’s Health Network (NWHN)

In addition to contesting the aforementioned procedures, feminists also began questioning the routine prescribing of tranquilizers and birth control pills to female patients as well as the routine recommendation for radical mastectomies in breast cancer patients. Another example of questioning the safety of widely prescribed treatments was the case of Belita Cowan and the effects of diethylstilbestrol (DES), “the morning after pill” which was widely prescribed to college students as a contraceptive after unprotected sexual intercourse. Cowan’s concern was heightened when she became aware of research the linked maternal ingestion of DES with cancers in daughters. With a group of local women who had been patients at the University of Michigan’s student health center, Cowan organized Advocates for Medical Information (AMI) to educate women about DES and to oppose the use of the morning after pill at student health centers in the United States.74

In 1974, Seaman, Cowan, and three other feminists (psychologist Phyllis Chesler, physician Mary Howell, and activist and attorney Alice Wolfson) united to found the

74 In 1971, with a grant from student government, AMI undertook an independent survey of women who had taken DES as a contraceptive. Of the sixty-nine women who responded to the AMI survey, only one quarter of them had even been contacted by health service doctors after their treatment with DES.
Washington-based lobbying group, the National Women’s Health Network (NWHN).\(^75\) By the end of the 1970s, a loosely connected women’s health network stretched across the nation with various levels of organization that monitored health policies aimed at women. In addition to challenging mainstream medicine, introducing the public to alternative medicine, and demanding women’s rights to own their bodies, the women’s health movement created a relatively rare opportunity for cross-class and interracial activism. This rare opportunity, however, would require that the majority of middle-class, college-educated, white women’s health advocates realize that their point of reference differed greatly from their other sisters who represented a myriad of color and class.

Indeed, foundational to understanding how women of color experienced women’s health activism is to first recognize that their sociopolitical context differed greatly from their middle class white counterparts. As Sharon Gary-Smith explains, “Black women always faced a multiplicity of issues-whether from racism and sexism, classism, or substandard housing, chronic financial limitations and unemployment. Therefore, unlike in the white women’s movement, support groups for Black women would have to require a broader definition of our problems and a specially designed program…. one that provides a forum to participate in dialogues with sisters and results in taking action to make change in our lives. Self-help is a chance to make a place for all of us to explore our collective history, to analyze our past and to identify our struggles and triumph as we move to wellness.”\(^76\)

**The Welfare State and the National Welfare Rights Organization (NWRO)**

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\(^75\) Morgen, *Into Our Own Hands*.

The MCC and MCA midwives and their partners worked with many women who relied on the government for welfare services. Felicia Kornbluh reminds us that “the feminist victories of the period were of limited importance to welfare mothers.” Yet welfare mothers did organize in an attempt to bring about social change. They posed important questions about the societal structures of poverty, employment, and parenting. They drew on and transformed Anglo-American legal and political traditions and the rights discourse of post-war U.S. Central within their approach to politics was a vision of citizenship. Welfare recipients and their allies believed that the rights for mothers that had been written into public policy in the New Deal period should be applied to all low-income parents and not just to the respectable white women who had been their primary beneficiaries in the years between the New Deal and the 1960s. They saw the U.S. as an affluent society in which citizenship entailed access to the same consumer goods as others. Citizenship meant full participation in the economic, legal, and governmental institutions that shaped people’s lives.

The welfare rights movement that started in 1966 was another social movement that garnered its energies from the civil rights movement. Independent groups of women receiving Aid to Families with Dependent Children (AFDC), a joint federal and

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78 Ibid.
79 Premilla Nadasen explains that civil rights activists did not universally support welfare rights, however, many welfare recipients and organizers who became involved in welfare rights got their political training in the civil rights movement. She also adds that although white welfare recipients usually did not have the same close ties to the civil rights movement as Black participants, the civil rights movement served as a conduit in a different way for them. Many of the Students for a Democratic Society (SDS) leader who helped initiate welfare rights groups first worked in campaigns for Black civil and voting rights. See “Welfare’s a Green Problem: Cross-Race Coalitions in Welfare Rights Organizing,” in Feminist Coalitions: Historical Perspectives on Second-Wave Feminism in the United States, ed. Stephanie Gilmore (Urbana: University of Illinois Press, 2008), 181-182.
state program for poor single mothers and their children, came together in their local communities to discuss ongoing problems with their caseworkers and the welfare department. They developed networks in small towns and mid-sized cities, in housing projects and rural communities. Often with the help of middle-class clergy or community activists, but sometimes on their own, these women began to speak openly of their economic hardship, their feelings of isolation and shame, their sheer frustration with the welfare bureaucracy, as well as their hopes and dreams for their children. Most importantly, they realized that by speaking collectively, they were a stronger and more powerful force to counter the daily indignities of welfare and to institute long-term reform. The welfare rights organizers’ demonstrations kept questions about economic justice and public benefits on the national agenda at a time when a rising conservative movement threatened to make them disappear.

The poor women involved in the midwife-led centers at MCC and MCA are representative of a welfare system in the U.S. that witnessed major transformations through the 1970s. At this time, the number of Americans eligible for welfare steadily climbed in large part due to the work of the National Welfare Rights Organization (NWRO). A group representing mostly single mothers, the NWRO sought to empower poor people by encouraging them to apply for public assistance, to demand welfare as a right, and not to accept it reluctantly and shamefully. 

80 Inspired by academic social scientists Frances Fox Piven and Richard Cloward, the NWRO aimed to organize welfare

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80 Bruce J. Schulman, *The Seventies: The Great Shift in American Culture, Society, and Politics* (Cambridge: DaCapo Press, 2001). Schulman argues the Seventies transformed American economic and cultural life as much as the 1920s and 1960s. The South was transformed by a booming economy and positive political spotlight. The “southernization” of American life ushered in a religious rebirth coupled with a declining faith in government programs, the legal and medical professions as well as academia and science.
recipients to demand the full benefits to which they were entitled and in so doing to disrupt the system enough to bring about lasting social change. Piven and Cloward envisioned this type of social change as one that would ultimately bring greater political power for the poor.\textsuperscript{81}

Beatrix Hoffman points out that the NWRO differed from many other activist groups that tended to focus on a single disease, condition, or policy. Instead, the NWRO tried to transform the fundamental nature of the U.S. health care system. Hoffman points to NWRO’s targeting of specific health care institutions including Medicaid and hospitals, but always with the broader vision of ending the two-tier health care system in the U.S. that offered access to care for those who can pay and inferior or no care for those who cannot.\textsuperscript{82} Despite not achieving the removal of the tiered health care system in the U.S., women on welfare were crucial actors in forcing hospitals to begin fulfilling their obligations to provide some free care to impoverished patients. The NWRO movement was influential in the creation of a language of patient rights. The activism by the poor carried a particular kind of power, and when women on welfare stood up to challenge entrenched health care institutions, their voices could not be ignored.\textsuperscript{83}

\textit{A Shift to Health}

Responding to the political firestorm and increased hostilities to the poor and Black by the political establishment and the public, the NWRO and its supporters began revamping their policies and strategies. In the NWRO, women leaders made an attempt to


\textsuperscript{83} Ibid.
emphasize the “rights of children” on AFDC, rather than the general welfare rights of the poor, most of whom were women. Increasing public resentment to welfare, inflammatory rhetoric about “lazy welfare mothers” by national political leaders, and the internal conflicts within NWRO were forcing it to reevaluate its structure and direction.  

**Negative Public Images**

Shifts in purpose also related to the negative images poor women endured, that were brought to the fore in 1965 with the publication of Daniel Patrick Moynihan’s *The Negro Family: A Case for National Action*. It offered a devastating critique of the Black family. He located Black women as the key to the “tangle of pathology” that marginalized Black men, crippled Black children, contributed to the rise of illegitimacy and perpetuated the “cycle of poverty and disadvantage.” As Patricia Hill Collins argues, until the growth of modern Black feminism in the 1970s, analyses of Black motherhood were largely the province of men, both white and Black, and placed the blame for “pathology” on low-income unmarried Black women. In this genre, Black mothers failed to discipline their children, emasculated their sons, defeminized their daughters, and retarded their children’s academic achievement, leading to an unbroken cycle of poverty.

Some feminists argue that by categorizing women as “deserving” and “undeserving” based on marital or employment status, the welfare state also played a substantial role in society’s stereotype formation of low-income women. For example, Collins argues that these racist and sexist “controlling images” permeate social structure

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to such a degree that they become hegemonic, namely, seen as natural, normal, and inevitable.\footnote{Ibid, 79-80. Further insight into the impact of controlling images on social structures can be read in Guida West’s exploration of the rise and fall of the National Welfare Rights Movement. West argues that despite its work against power dynamics in society, the NWRO workers would often use language that imparted powerlessness when working with low-income communities. See Guida West, \textit{The National Welfare Rights Movement: The Social Protest of Poor Women} (New York: Praeger, 1981).} Low income women who withstood the tragedy of losing an infant often had to contend with the assumptions supporting these “controlling images” in addition to deplorable living conditions, health problems, inadequate education, domestic violence, lack of child care, the public discourse on poverty, and the policies implemented by public institutions. All of these factors influenced the health of the women and their children as well as disempowering their ability to participate in health decisions.

\textbf{Black and Minority Women’s Health}

Thus, during the national women’s health campaign, minority women found themselves struggling to find their place within the platform promoted by their white, middle and upper class cohort. One example of the effort of minority women to define themselves within the larger women’s health movement was initiated by Byllye Avery, an African American woman working in the Children’s Mental Health Unit at Shand’s Teaching Hospital in Gainesville, Florida. Avery was known in her community as someone who had the phone number of a doctor in New York City who performed safe but illegal abortions. She realized this abortion referral was of little use to many women, especially those with low incomes, because they could never afford the cost of the abortion and travel north to New York. When abortion was legalized, she and several friends founded the women-controlled Gainesville Women’s Health Center. Avery
helped to found an alternative birthing center. In the interval, she was invited to serve on the board of directors of the relatively new National Women’ Health Network (NWHN).

Avery was acutely aware of how little information existed about Black women’s health and of how the movement she was part of defined issues, strategies, and services with little attention or awareness to the specific needs and perspectives of women of color. As a board member of the NWHN, she envisioned a grassroots approach to bring Black women together to define their own health needs and develop their own strategies for change.

Gradually, a diverse group began to plan a conference on Black women’s health. At the same time, Avery and her colleagues researched health issues important to Black women and worked to facilitate the information of what she called self-help groups. Avery’s self-help for women of color differed from that of their white sisters. “At first we would get together using the regular health education model: talk about high blood pressure and talk about weight. Soon, I found out that what women needed was a sense of building self-esteem, a sense of empowerment. So many women felt that they had no control over their own lives; that things were just happening to them and that was quite difficult. So we really worked a lot in the psychological domain.”88 By the summer of 1983, more than a dozen self-help groups associated with the National Black Women’s Health Project (NBWHP) were in operation, mainly in the southern United States, but also in Rhode Island, New Jersey, Pennsylvania, Minnesota, Michigan, and the San Francisco Bay Area. In March 1984, the NBWHP became an independent organization.

88 Morgen, Into Our Own Hands. 44.
Women of color needed their own voices and were determined to connect to the larger women’s health movement on their own terms.

This review shows that historically, there has been a long record of public health campaigns by Black women. Issues surrounding reproductive rights have been an enduring and consistent thread throughout the movement of Black women and health. Yet many in the NBWHP witnessed reluctance on the part of the white women’s health and reproductive movements to be effectively concerned about issues Black women faced in the realm of reproductive rights. Issues such as forced sterilization and the loss of Medicaid funding for abortion were viewed as major areas of concern for Black and minority women.

Variations of Race and Class

Getting together and discussing perceptions of problems and issues was a salient difference between the predominantly white women’s health movement organizations and minority organizations such as NBWHP. Groups may have shared a vocabulary that included terms such as self-help and empowerment but these terms held different meanings as a result of the user’s sociopolitical context. In many of the organizations and publications of the white women’s health movement, self-help was first and foremost a referent to women taking decisions about their bodies and health into their own hands.

89 See Susan Smith’s Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890-1950. Smith argues that from 1890 to 1950, many African Americans viewed their struggle for improved health conditions as part of a political agenda for Black rights, especially the right to equal access to government resources. Black health reform was gendered to the extent that men held most of the formal leadership positions and women did most of the grassroots organizing. Much like the Black civil rights movement of the 1950s and 1960s, men led but women organized. Smith contends that much of the history of Black health work is the history of laywomen.


91 Morgen, Into Our Hands.
The concept was first used to talk about cervical self-examination and soon afterward, menstrual extraction. Yet the concept and practice of self-help as it developed within the NBWHP held a different referent and meaning. One NBWHP member explained self-help groups as “designed to provide a safe, validating environment for us to learn how to come together to share our stories, to be appreciated for the struggles we have all participated in, to review our circumstances, and to make decisions designed to change our lives and our health circumstances.”92

The emphasis on talking, sharing, and telling stories also encompassed recognition that Black women always faced a multiplicity of issues such as racism and sexism, classism, or substandard housing, chronic financial limitations and unemployment. Therefore, unlike the predominantly white women’s movement, support groups for Black women had to contain a broader definition of their problems and a specially designed program. As Gary-Smith articulates, “self-help was a chance to make a place for all of us to explore our collective history, to analyze our past and to identify our struggles and triumphs as we moved on to wellness.”93 The matrix that situated Black women’s problems viewed gender, race, and class as fundamentally interconnected in Black women’s lives. Whereas the predominantly white women’s health movement emphasized hands-on knowledge of their bodies, the Black women’s health movement emphasized sharing their stories, information, and struggles. Founder Avery credited this

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93 Ibid.
form of self-help as a powerful tool that worked to break the “dangerous conspiracy of silence amongst women of color.”94

Another distinguishing difference between the NBWHP and some of its sister health organizations was its critique of professionalism. In the predominantly white health movement organizations, there was a strong critique of the professional dominance of health care that was less salient for women of color health organizations. Rather, for these women, access to these providers was the cornerstone, especially in the form of bringing these professional health services into their communities.

Other Voices and Stories

The National Latina Health Organization (NLHO)

Sandra Morgen’s examination of several women’s health clinics during this time focuses on how the NBWHP provided inspiration for other women to coalesce over women’s health. The National Latina Health Organization (NLHO) formed as a result of some of the founders hearing NBWHP members speak at conferences. Inspired to formulate an organization that could speak to both similar and unique concerns as other women of color, the NLHO was formed to raise the consciousness, improve the health, and foster the empowerment of Latinas. The organization was also committed to work toward the goal of bilingual access to quality health care and the self-empowerment of Latinas through educational programs, outreach and research. The issues Latinas faced varied from their other sisters in women’s health as their histories emerged from various

historical, economic, political and cultural contexts. The NLHO founders drew strength from these differences in language, ancestry, immigration status, and sexuality. Reproductive justice was an important cornerstone of organizing for Latinas nationally. It was commonly believed that issues of reproductive health and sexuality were not of concern to Latinas or their communities due to the predominance of Catholicism in this community. Despite this trend, NLHO members pointed to an abortion rate among Latinas of 42.6 per 1,000 compared with 26.6 for non-Latinas. Additionally, Latinas in the age range of fifteen to forty-four comprised 8.4 percent of the population, but they accounted for 13 percent of abortions. Still, the NLHO’s newsletter declared “Reproductive choice for us is much more than abortion – it is the ability to have healthy babies when and if we want. It means the freedom to choose to have one child or ten. Or even none. Reproductive choice means access to culturally relevant, quality health care and information, education about sexuality and contraception for our daughters, and access to alternative forms of birth control, regardless of cost.”

The Native American Women’s Health Education Resource Center (NAWHERC)

The history of the Native American Women’s Health Education Resource Center (NAWHERC) started in a similar way to the NLHO. Women witnessed their different representatives of minority sisters develop programs that worked and from these

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95 Morgen, Into Our Own Hands.
98 Latinas for Reproductive Choice (LRC) was a short-lived program of the NLHO and its coalition work with other mainstream and women of color organizations. Formally initiated on the thirteenth anniversary of Rosie Jimenez’s death, LRC declared that Latinas “will no longer stand on the sidelines and let others decide our fate.” They visualized their work as a link between Latinas and the larger pro-choice community. See Jael Silliman, Marlene Gerber Fried, Loretta Ross and Elena Gutierrez, eds., Undivided Rights: Women of Color Organize for Reproductive Justice (Cambridge: South End Press, 2004).
observations gained the confidence that they, too, could form a coalition that spoke to their unique needs. In 1985, a group of women living on and near the Yankton Sioux Reservation in South Dakota began to meet to discuss health and other issues of concern. The process began, as it did so often in the women’s health movement, with informal discussions at the home of Charon Asetoyer, a Comanche woman who was married to a Dakota Sioux man. Asetoyer’s activism were deeply influenced by the philosophy of the American Indian Movement (AIM); she believed that indigenous rights, sovereignty, and nationhood were closely tied to community health issues and that a community needed to be healthy to ensure its political rights. Asetoyer and her husband started the NAWHERC as an organization specifically committed to improving the health of Native American women living in North Dakota, South Dakota, Iowa, and Nebraska where 54.5 percent of the Native American population lived below the poverty line.

Retrieving, nurturing, and affirming Native culture and spirituality is central to NAWHERC’s philosophical and political orientation. This orientation grounds the center’s work, which includes providing direct services, conducting research, organizing advocacy programs, and forging coalitions with other Native American women in the framework of cultural renewal and Native sovereignty.

*The National Asian Women’s Health Organization (NAWHO)*

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99 Silliman, *Undivided Rights.*
100 Ibid. Prior to founding NAWHERC, Asetoyer worked for the American Indian Health Clinic and sat on the board of the American Indian Center in San Francisco. She also served as the director of the Health Program for Women of All Red Nations (WARN) for the Yankton Sioux, Cheyenne River, and Standing Rock Reservations. After completing her criminal justice degree at the University of South Dakota, Asetoyer and her husband began to work locally on women’s health by identifying several unmet needs. Together they founded the Native American Community Board (BACB). In 1988, three years after starting work in the community, NACB purchased a building and incorporated the Native American Women’s Health Education Resource Center.
101 Ibid.
Asian women have been active in struggles for their rights since the 1960s when Asian women began organizing on a larger scale to address issues of particular concern to their communities such as trafficking, reproductive rights, gay and lesbian rights, and domestic violence. The experiences of Asians in the U.S. have been shaped by a long history of restrictive anti-immigration policies. As a form of population control, U.S. immigration policy had short and long-term consequences for Asian women’s reproductive freedom, rights, and lives.\textsuperscript{102}

Since the Chinese Exclusion Act of 1882 and lasting until the mid-1960s, Asian women’s entry into the US was even more strictly controlled than that of their male counterparts. As racism against the Chinese increased, Chinese women were characterized as prostitutes and singled out for moral condemnation and control by legislators and the police. Historian Sucheng Chan argues, “The impressions that all Asian women were prostitutes, born at that time, colored the public perception of, attitude toward, and action against all Chinese women for almost a century. Police and legislators singled out Chinese women for special restrictions and opprobrium, not so much because they were prostitutes as such but because, as Chinese, they allegedly brought in especially virulent strains of venereal diseases, introduced opium addiction, and enticed white boys to a life of sin.”\textsuperscript{103}

Other Asian women, Japanese, Korean, Filipino, and Indian, have had exclusionary experiences similar to those of Chinese women. At one time or another,

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\textsuperscript{102} For the purposes of this dissertation chapter, the term Asian does not designate a single, monolithic culture.

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each group was denied entry into the U.S., and if they did succeed in immigrating, they faced discrimination, stigmatization, and exploitation. Additionally, coming to the U.S. later than their husbands meant women encountered a world that was familiar to their husbands, but not to them. They were severely disadvantaged by language, law, and custom and were economically dependent on their husbands. Entering the U.S. as wives also meant their legal status was contingent on their husband’s sponsorship, further increasing their vulnerability in the home as well as in the larger society.104

It was not until 1993 that Mary Chung, a community activist born in Korea and living in Oakland California, founded the National Asian Women’s Health Organization (NAWHO). It was founded as a nonprofit, community based health advocacy organization committed to improving the physical, emotional, mental, and social well-being of women of Asian descent. It conducted research and promoted the development of affordable, accessible, and culturally appropriate reproductive and sexual health services.105

As a result of these women of color organizations, the voices of minority women became significantly more audible in their efforts to develop a health care system that could admit and reform its legacies of exclusion, inequity, and harm. The NBWHP, NLHO, NAWHERC, and NAWHO and their sister organizations worked to break the silence that isolated women of color within the women’s health movement. As Morgen argues, the legacies of racism within the reproductive and women’s health movements

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105 See the National Asian Women’s Health Organization 1993-1994 Report. NAWHO; and Morgen, *Into Our Own Hands*. 
remain, but they are contested and alternative voices exist. In addition, predominantly white women’s health organizations were challenged to better address the needs of the injustices of racism and the needs of various women of color.\textsuperscript{106}

**Feminist Clinics, Radicals, and the New Right**

As historian Berger asserts, “the 1970s was a moment when social movements experimented and expanded. Inspired by the movements they helped build or in whose shadow they worked, some radicals in the 1970s committed to trying new things.”\textsuperscript{107} Berger explains that the political formations or strategies these activists employed included new languages as they rejected directions and patterns that did not work in the past and experimented with alternative praxes. These alternative political communities were led by people whose voices or perspectives had been unheard a few years earlier: women, indigenous peoples, gays, lesbians, bisexuals and transgender people. More so than their 1960s counterparts, many of these groups were committed to addressing the ways power inequalities reproduced themselves within social movements and not just outside of them. Nevertheless these movements still identified community as their goal, as they sought to build from the ground up organizations and institutions able to both meet people’s needs and withstand the reaction of state institutions.\textsuperscript{108} The women’s health movement, its energy, participants, and organizations were no different.

**Feminist Clinics and Radical Ideas**

\textsuperscript{106} Morgen, *Into Our Own Hands*.

\textsuperscript{107} Berger, *The Hidden 1970s*, 5. A separate group of scholars, including some activist veterans of the era, challenged any neat decade-based periodization. Their stance is that the grassroots politics of the “long sixties” stretched from the 1950s to the 1970s. By emphasizing women’s liberation, Black Power, and anti-imperialism, among other movements of the time, these scholars have shown that some of the most significant aspects of “the sixties” actually occurred in the 1970s. Ruth Rosen argues that the 1970s was “arguably the most intellectually vital and exciting period in the history of American women.”

\textsuperscript{108} Berger, *The Hidden 1970s*. 
In summary, in the 1970s women from all over the country were attracted to an emerging women’s health movement. Ruzek estimated there were at least one thousand organizations directly involving women in various forms of health activism. Many of these women-controlled health clinics were organized either on the eve of or the immediate aftermath of Roe vs. Wade. Morgen calls this the most “important historical marker in understanding the emergence of the clinic movement.” In most of the feminist clinics operating during the early 1970s, women owned, operated, and made the decisions in the clinics they founded. It also meant that many of the women were not medical professionals.

There were several important differences that distinguished a feminist clinic from mainstream women’s health clinics. Self-help was the cornerstone of the feminist clinic. From offering women the most basic information about their bodies to the most radical acts such as self-cervical examination, feminist clinics displayed a strong preference to female practitioners that included a wide spectrum from nurse practitioners to lay health workers. An essential element of the critique of the male-dominated health care system at this time was its over-medicalized treatment of many of a woman’s natural passages of their reproductive lives. Birth control, abortion, pregnancy, childbirth, menstruation, and menopause were facets of women’s lives that historically were controlled by women.

Feminists criticized the organization of capitalist health care that placed profits of doctors, hospitals, pharmaceutical, insurance companies and others above women’s need for health services. The feminist response was to provide free, low-cost, or sliding scale

109 Ruzek, The Women’s Health Movement.
110 Morgen, Into Our Own Hands, 70.
111 Ehrenreich and English, Witches, Midwives, and Nurses.
based services whenever possible. Often, this placed a number of feminist clinics at a financial loss. Clinics varied in their handling of patient charges and as a result this became a source of internal conflict. Feminist clinics also challenged the impersonality and instrumentality of the bureaucratic procedures of many traditional workplaces. The fundamental philosophical premise that the “personal is political” was translated into a work environment that tried to incorporate the personal needs of its employees into the work place.112

As feminist literature grew and the movement began to mobilize in the way of self-help groups and women-controlled clinics, physicians, especially obstetricians and gynecologists, took note. In 1974, Barbara and Irwin Kaiser presented a paper, “The Challenge of the Women’s Movement to American Gynecology,” at the ninety-seventh meeting of the American Gynecological Association in Hot Springs, Virginia. The fact that this paper was presented testifies to the growing influence of the women’s health movement.113 The paper did show some sympathy to the feminist critique of medicine admonishing physicians to understand the social and political implications of women’s health as feminists desired. However, the Kaisers raised concerns about whether self-help, especially menstrual extraction, might be dangerous.114 Despite some support from the readership, many responses from fellow obstetrician/gynecologists dismissed the feminist argument as a product of the “lunatic fringe” of the women’s movement.115

112 Morgen, Into Our Own Hands, 76.
113 Ibid, 124.
115 Morgen, Into Our Own Hands, 124.
Even as the physician backlash occurred, the late 1970s also witnessed affirmative action and the entrance of more women and students of color into the medical profession. Several physicians played leadership roles within key women’s health advocacy organizations, and many others were instrumental in either the founding or staffing of health clinics. One example was Dr. Mary Howell, who received the National Women’s Health Network’s first Physician Service Award. Howell, one of fourteen women admitted to Harvard’s Medical School in 1958, made a radical proposal while giving a speech at a national women’s conference in 1975. She proposed the idea of opening a medical school for females only, one that would develop the kind of physician who had more feminine traits, such as collaboration, nurturance, and a desire to serve others.116

Another physician who left a lasting imprint on the women’s health movement is Dr. Helen Rodriguez-Trias, a woman of Puerto Rican ancestry born in New York City but who grew up in Puerto Rico. Like Howell, she was married, and by the time she graduated from medical school she had three children. Profoundly influenced by the Puerto Rican nationalist movement, Rodriguez-Trias was not a stranger to politics when she became involved in health activism through her work at Lincoln Hospital in the Bronx where she practiced pediatrics and eventually served as the head of that department. Rodriguez-Trias was acutely aware of the health issues, especially women of color, confronted. She understood gender as only one dimension of the healthcare picture, that race and class were inextricably tied into the treatment of her patients. Rodriguez-

Trias was instrumental in the creation of both the Committee to End Sterilization Abuse (CESA) and its ally the Committee for Abortion Rights and against Sterilization Abuse (CARASA).\textsuperscript{117}

At first, CARASA represented a coalition of groups that ranged from liberal and mainstream to socialist feminist, including the National Abortion Rights Action League (NARAL), NOW-NY, the National Political Caucus, the Center for Constitutional Rights, CESA, Feminist Healthworks, Mass Party Organizing Committee, Medical Committee for Human Rights (MCHR), Socialist Workers Party, and International Socialists. The women who created CARASA wanted to secure reproductive control for the least-advantaged women, the poor, the young, and women of color.

Within CARASA, feminists, many of whom identified as socialists, demanded federally funded abortion, and end to sterilization abuse, occupational health and safety and state-subsidized high quality child-care. Their broad focus was a substantial shift from the pre-\textit{Roe v. Wade} feminist abortion rights organizing in that they identified a matrix of political demands centering on economics that had to be secured before reproductive freedom became a reality.\textsuperscript{118}

In addition, this organization held a class focus that set them apart from other abortion rights groups. Many of the founding members had been involved in New Left organizations, which shaped their interests in addressing class oppression. They had connections to the student movements of the late 1960s such as the SDS and to the anti-Vietnam War campaigns. Furthermore, many of the white and middle class CARASA

\textsuperscript{118} Ibid.
members had sharpened their political skills in the civil rights movement, in the feminist movement, and in Marxist groups. The socialist orientation of the majority of CARASA’s early constituency encouraged them to emphasize economic access to reproductive freedom as the central focus of their politics.119

The Young Lords and Black Panthers

Considered a radical Black organization and stereotyped by the media as a violent group of angry Black men and women, the Black Panther Party also has a history of profound health rights work and community building. Alondra Nelson’s work is premised on questions surrounding challenges to biomedical racialization and the Black protest tradition.120 She examines how the Black Panthers were heirs to a mostly uncharted tradition of African American health politics. This tradition, from the long civil rights movement, has consisted of health advocacy, variously conceived. The Panthers also inherited a legacy of tactical responses to racialized health inequality, including institution building, integrationism, and the politics of knowledge. “Serve the people body and soul” was the Black Panther mantra, one that signaled the group’s total dedication both to health and improving living conditions and other effects of societal displacement and marginalization towards Blacks.121 As health activists in the late 1960s and early 1970s, the Panthers held relationships with hippie counterculturalists, leftists such as Students for a Democratic Society (SDS), MCHR, and other allies in the

119 Nelson, Women of Color and the Reproductive Rights Movement. As a result of their broadened definition of reproductive rights, CARASA lost support from NARAL after their agenda was created.
121 Ibid, 10. Similar to the Maternity Care Coalition’s use of vans to provide health services to communities, the Black Panthers used retired ambulances and other vehicles to reach impoverished communities of Black residents. They also offered health screening services, as well as sickle cell anemia testing, and health teaching.
“rainbow coalition,” such as the Young Lords. The latter, a multiracial group of Puerto Ricans, also developed a radical political stance during the 1970s that encompassed feminism within a nationalist stance.122

**The New Right**

The major gains of the women’s health movement during the 1960s and 1970s met a formidable opponent in the 1980s. The growth of the New Right and the presidencies of Jimmy Carter and Ronald Reagan marked a new decade of challenges for the men and women in the women’s health movement. The effects of this decade actually started in the late 1970s when abortion foes scored an important victory with the passage of the Hyde Amendment in 1976. The Hyde Amendment prohibited the use of federal funds for Medicaid funded abortions. By 1979, no federal funds could be used for abortion or abortion-related services unless a woman’s life was in danger. At the same time, state legislatures across the country were passing laws that limited abortion rights and access, including the requirement of parental consent for minors and spousal consent or notification for all women who sought abortion, waiting periods, and restrictions.123

Carter was a moderate Southern Baptist and a relatively conservative Democrat. This combination helped win over both religious and secular voters. Carter supported banning Medicaid for abortions but opposed a constitutional amendment against abortion. In addition to the abortion debate, the 1970s saw rising divorce rates as well as higher rates of children born out of wedlock. Carter utilized this time to court the religious and evangelical right with his decision to hold a ‘White House Conference on the Family’

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123 Morgen, *Into Our Own Hands.*
Duane Oldfield explains that the family was particularly important to evangelicals as a “realm of nurturance isolated from the competition of the market, a private realm in which women promoted values threatened in the world outside.”

The 1980s witnessed the parts of the New Right coming together for a 1980s presidential campaign that focused particularly on reproductive, sexual, and family issues. The New Right was composed of single issue, political and religious organizations with somewhat divergent concerns. Reagan and the Republican Party were able to maneuver these ideals into an effective political platform that mobilized the country into his victory in the 1980 election.

The period of time before the 1980s that served as the economic foundation for Reagan and his presidency was characterized by stagflation in US economy. Stagflation during this period witnessed persistent inflation and a pattern of growth that was sluggish at best, interspersed with the worst recessions of the postwar period. The Reagan administration's program to combat economic crisis included massive cuts in social services, tax cuts that favored the rich and corporations, actions to weaken labor unions, and policies that fostered and exacerbated a severe recession. The outcome of such policies was a redistribution of income from poor and working people to wealthy individuals and corporations.

Reagan policies affected poor and working-class men and women, but it was especially poor and non-white women who felt the full force of his budgetary decisions.

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Reagan’s economic policies witnessed a 60 percent cut in federal entitlement programs for the poor in fiscal 1982. Aid to Families with Dependent Children (AFDC) was cut by approximately $1 billion, Medicaid was cut by an estimated $800 million, food stamps by $700 million, with approximately 875,000 people eliminated from the food stamp program. The 1983 fiscal budget dealt similar blows to these programs. The plans were part of a long-term plan to save $30 billion in domestic spending programs over three years, including a decrease of more than $17 billion in federal health and welfare programs.127

In what Diana Pearce labeled the “feminization of poverty,” the number of low-income women raising children alone increased starting in the 1970s.128 Many of the conservative policies implemented in the 1980s not only slashed federal spending for social programs but also transferred the responsibility for many of these programs to state and local governments. Implementation of the Omnibus Budget and Reconciliation Act of 1981 led to huge cuts in grants-in-aid programs to state and local governments and in means-tested programs for the poor.129 In addition to reductions in aid, the federal government consolidated a wide variety of categorical grants into block grant programs that handed states and localities less money and more discretion in how to spend it.130

During this financially unstable period, many turned to patchwork funding from foundations and to community based fundraising. Some clinics were forced to recover

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130 Morgen, Into Our Own Hands.
costs from fees that ultimately interfered with the goal of keeping health care affordable. Many of the clinics resorted to laying off staff, reducing staff benefits, and reducing non-revenue generating activities, such as education, outreach, or advocacy. Nevertheless, many of these organizations managed to survive. Some of the clinics that did survive the Reagan years also opted to be managed by mainstream health groups such as county health departments or to be bought out by physician-owner partnerships. In addition to the financial stressors of this era, the escalating power of the New Right also witnessed harassment and violence against those clinics that provided abortions.¹³¹

Following the legacy of the many organizations described in this chapter and driven by concerns over infant mortality, MCC and MCA were formed to help women, especially poor women and women of color, to regain control over their own health care. While similar collaborations occurred at the local grassroots level, the MCC and MCA included nurses as key actors. The next two chapters focus on these organizations, situating them within the 1970s women’s health movement and the political backlash of the 1980s.

Chapter Three

The Maternity Care Coalition

¹³¹ Ibid.
The totality of energies emerging from the larger women’s health movement supplied valuable momentum to Philadelphia’s efforts to maximize women’s health. Philadelphia’s MCC was founded in 1980 and originated as a subcommittee of the Women’s Health Concerns Committee (WHCC). The Southeastern Region of the Pennsylvania Department of Health created the WHCC in the fall of 1974. Its major
emphasis rested with the concern that there should be more communication between the
government of Pennsylvania and women’s organizations.\textsuperscript{132} This chapter examines how,
in the 1980s, MCC activists employed various strategies to not only bring the problem of
persistent infant mortality into public visibility but to also hold area hospital systems
accountable and committed to caring for women and children. The style of activism that
MCC exemplified was ground up and coalition building as they reached out to area
groups and organizations to join the cause of bringing Philadelphia’s tragically high and
persistent infant mortality in to public view.

Nationally, women and their children represented a majority of large urban cities’
marginalized poor. Despite the rising momentum of the national women’s movement (as
noted in Chapter 2), it did not supply adequate representation to the needs and concerns
of poor, minority women. At this point, other women of color formed grassroots
collectives to address health related needs of these marginalized women. Philadelphia
was no exception. When the Maternity Care Coalition (MCC) formed in the 1980s, it
followed on the heels of several of these women’s activist groups that began in the 1970s.

**Philadelphia’s Black Community**

As black women contended with growing rates of infant mortality in 1970s
Philadelphia, black political and community activists were assembling over issues of
political representation in their communities.\textsuperscript{133} On April 26, 1970, 900 black political

\textsuperscript{132} Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection,
ARBML. The emphasis on increased communication between government and women’s organizations
came as a result of a three day 1974 Conference on Women & Health that was co-sponsored by the
Southeast Region of the Health Department and Commission on the Status of Women in cooperation with
the Governor’s Office of the Commonwealth of Pennsylvania.

\textsuperscript{133} Matthew J. Countryman, *Up South: Civil Rights and Black Power in Philadelphia* (Philadelphia:
University of Pennsylvania Press, 2006).
and community activists in Philadelphia attended the founding convention of the Black Political Forum (BPF). The BPF’s founder and first president was John White Sr., a salesman and longtime West Philadelphia community activist with a booming voice and an intimidating presence. White told the gathering that the forum’s purpose was to make the black community’s political representatives more responsive to the community’s needs and more accountable to their constituents. “Let the politicians know that we demand representation,” he urged his audience. “Right now, the leaders do not consult the people in the community or anything. They just vote the party line, the people are out of it.”

Black community activists also identified health care delivery as an area where their voices and concerns were not represented. Philadelphia General Hospital (PGH) represented one component of this struggle. Situated as a hospital that cared for the indigent, Philadelphia General Hospital was the center of a contentious battle to close its operation in February 1976. Philadelphia Mayor Frank Rizzo, who was viewed suspiciously by many in the black community, faced massive criticism for his final decision to permanently close PGH’s doors. Echoing the sentiment of many in the black community, Dr. Austen Sumner, a member of PGH’s medical staff, went on record with a statement that included, “Our patients cannot be cared for elsewhere, and we believe that they will suffer if PGH closes.”

136 O’Donnell, Provider of Last Resort, 68.
Leading up to Rizzo’s decision to close PGH were multiple newspaper reports of severe nursing shortages alleging less than standard patient care. On January 28, 1976, the firestorm of accusations came to a head on the front pages of the *Daily News*. Posing as an “ail ing derelict,” reporter Hoag Levins described the less-than-humane care by staff and deplorable patient conditions accompanied by pieces looking at the multiple studies commissioned on PGH.\(^{137}\) Despite the accounts of substandard care, there were those in the black community who voiced concerns over PGH’s administration. Citing a lack of African Americans on the board of PGH or in any leadership position, many felt the hospital’s demise could have been prevented had adequate funding been appropriated.

On February 21, 1976, the black political community stepped into the contentious deliberations over the closing of PGH. The NAACP, led by regional director Jerry Guess, threw its support behind a demonstration scheduled with PGH union members. In addition, Edward Sparer, a University of Pennsylvania Professor of Law who specialized in welfare rights, unsuccessfully argued against Common Pleas Judge G. Fred DiBona’s ruling that the city was not legally required to maintain a public hospital.\(^{138}\) The black political community and minority citizens shared a growing concern that, despite Mayor Frank Rizzo’s promises that private hospitals would absorb and care for the PGH patients, the marginalized poor would continue to suffer. It was in this social and political context that MCC was established.

**Philadelphia’s National Black Economic Development Conference (BEDC) and Triple Jeopardy**


An organization that influenced MCC was the National Black Economic Development Conference (BEDC). Another significant group that actually partnered with MCC was Triple Jeopardy. Within the political unrest in 1970s’s Philadelphia, black grassroots organizations grew in number and political strength. Cynthia Waters, a black Philadelphian and community activist who eventually became the Director of Program Operations and Community Development of the MCC, was a member of the National BEDC.\(^{139}\) It was started as an effort to build the case for reparations to the black community for the alleged participation or complicity of groups in the institutional arrangements that had disadvantaged African-Americans over the years.

Waters went on to form Triple Jeopardy as a coalition within the local BEDC.\(^{140}\) Waters came from a long family line of black feminist thought and social activists. Triple Jeopardy was representative of rising black women’s feminist ideologies during the 1970s and was an example of one of many organized collectives’ by minority women as a result of the oversight by the national women’s movement to address poor and minority women’s concerns and issues. Initiated in 1972, Triple Jeopardy became one of Philadelphia’s first organized black feminist support coalitions inspired by the Relf Sisters’ sterilization abuse case in Alabama.\(^{141}\) Waters explained that in Philadelphia,

\(^{139}\) Matthew J. Countryman, *Up South: Civil Rights and Black Power in Philadelphia* (Philadelphia, University of Pennsylvania Press, 2006). Page 267-271. The National Black Economic Development Conference emerged from an April1969 takeover of the annual conference of the Interreligious Foundation for Community Organization (IFCO), an agency whose mission was to channel church funds to grassroots antipoverty and social justice groups. Led by James Forman, the former executive secretary of SNCC, the activists demanded that IFCO give control of its financial capital to the communities it claimed to serve. Forman’s speech to the IFCO served as the basis of “The Black Manifesto.” The manifesto demanded “white Christian churches and Jewish synagogues which are part and parcel of the system of capitalism begin to pay reparations to black people in this country.”

\(^{140}\) Oral history interview by Linda Maldonado with Cynthia Waters on September 11, 2012.

\(^{141}\) The Relf case involved the unethical medical experimentation of sisters Mary Alice and Minnie Relf as part of the U.S. Office of Economic Opportunity's family planning program in Montgomery, Alabama.
low-income, minority women were enduring discriminatory treatment during various women’s health related medical visits and procedures. She and her coalition realized the need to address the disparities faced by marginalized groups of women as a result of the “triple jeopardy” of race, class, and gender. In light of the larger national women’s health movement and its primary focus on middle and upper class women’s concerns, Triple Jeopardy became both a social support and political platform for minority women in Philadelphia.¹⁴²

Activists from Philadelphia’s Triple Jeopardy modeled their women’s health activism in a parallel fashion to many of the Black Panthers’ health activism strategies. The activists not only supported women’s health in the minority community, they also supported many Black Nationalist causes as well as involvement in the African liberation movements at the time. Triple Jeopardy also worked with other groups for social change and liberation such as the Asian community’s Yellow Seeds activist group in Philadelphia.¹⁴³ They also involved the Puerto Rican Young Lords and their families in their outreach.¹⁴⁴

Triple Jeopardy was funded by grants from the Episcopal and Presbyterian Diocese, as well as the American Friends Service Committee, a Quaker organization. In fact, the Quakers supplied an old 19th century building as a meetinghouse for the group in North Philadelphia in the highly black and Hispanic Germantown section.

¹⁴² Waters interview.
¹⁴³ Considered an important precursor to progressive Asian American political activism in Philadelphia, Yellow Seeds was an Asian American anti-imperialist organization established in 1971 that focused on the local Chinatown as well as city, national, and world affairs. Modeled after the Black Panther Party, Yellow Seeds also published their own paper, Yellow Seeds (1972-1977).
¹⁴⁴ As noted in Chapter 2, the Young Lords Organization was founded in 1968 upon the platform of independence for Puerto Rico as well as the improvement and empowerment of poor Puerto Ricans in the barrios of Chicago and New York City.
Waters explained that initially, Triple Jeopardy was primarily concerned with guaranteeing the reproductive rights of socioeconomically disadvantaged women of color.\textsuperscript{145} Unlike the larger national women’s reproductive rights movement that focused largely on abortion access, minority women also faced many cases of forced sterilization. Yet in Philadelphia, the leadership of BEDC, the majority of which was men, was not supportive of the Triple Jeopardy activists’ reproductive rights agenda. Philadelphia’s BEDC ideologically supported national claims by the Nation of Islam and the Black Panther Party that any contraceptive use among blacks would inevitably lead to the genocide of the population.\textsuperscript{146} This ideological divide over birth control and reproductive rights led to the threat of a lawsuit and Triple Jeopardy’s eventual split from the BEDC.

Triple Jeopardy activists recognized the prevalence of sexist attitudes from among both African Americans and other groups. Paternalistic attitudes also prevailed among many Philadelphia health practitioners as witnessed by Triple Jeopardy activists while chaperoning women to their providers’ appointments. These activists would accompany women to doctors’ appointments to lend quiet support or assist women in effectively vocalizing their concerns to providers.

As an example, in one situation, Waters recounted the story of a young black woman who wanted to stop taking birth control pills and try another form of pregnancy prevention. Her provider would not listen to the young woman, each time attempting a different dose or variety of the birth control pill. Waters accompanied this young woman to her next appointment and challenged the doctor’s rationale for continuing the birth

\textsuperscript{145} Waters interview.

control pills when the patient was experiencing numerous, consistent negative side effects. The doctor finally conceded and changed the birth control plan.147

Triple Jeopardy activists also accompanied women who were in labor to their hospitals in order to provide support but also to ensure “their rights were not being trampled on.”148 At the time, there were growing accounts of Philadelphia hospitals’ differential treatment of minority and welfare recipients. The support that Triple Jeopardy activists lent to laboring minority women differed greatly from the growing labor support and birth movement of the 1970s. The birth movement of the 1970s was again a primarily white, middle and upper class movement, similar to the national women’s health movement. Concerned with giving the laboring woman a respected and decisive voice in her labor and birth, the national birth movement fostered a new sense of empowerment with the birth process that advocates argued produced a healthier mother-baby couplet.

For most poor, minority women, however, the birth experience was often removed from their control due to their assigned status as a welfare recipient and the racialization of birth.149 Indeed, as Dorothy Roberts argues, white childbearing was generally thought to be a beneficial activity: it brought personal joy and allowed the nation to flourish. Black reproduction, on the other hand, was perceived as a form of degeneracy, with Black mothers seen as corrupting the reproduction process at every stage. According to these perceptions, they damaged their babies in the womb through their bad habits during pregnancy, then imparted a deviant lifestyle to their children.

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147 Waters interview.
148 Ibid.
149 See Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (New York: Vintage Books: 1997). Dorothy Roberts writes that as both biological and social reproducers, it is only natural that Black mothers would be a key focus of racist ideologies.
through their example. These representations of Black women’s bodies thus warranted strict measures to control their childbearing rather than wasting resources on useless social programs.\textsuperscript{150}

In this social environment, Triple Jeopardy activists counseled women to think carefully over any medical suggestions as to permanent sterilization procedures. In the oral history interview with Cynthia Waters, she shared that many minority women from Philadelphia found themselves convinced by medical practitioners to undergo hysterectomies during periods of the year when medical residents needed the surgical experience. Waters and the other activists in Triple Jeopardy sought to make sure their contingency of minority women were made aware of other pregnancy prevention measures in addition to the permanent sterilization measures.

Another component of race and medicine that was developing nationally in the 1970s was therapeutic pain management in African Americans with sickle cell disease. As Keith Wailoo argues, the early 1970s witnessed a growing acceptance of the pain and suffering endured by sickle cell anemia patients. However as the decade progressed, the authenticity of pain experienced by the disease’s victims fell under widespread societal scrutiny. Some viewed the pain relief sickle cell anemia victims sought as “drug-seeking” thereby casting the disease’s victims as suspicious and worthy of intense scrutiny.\textsuperscript{151} This societal shift in recognizing pain authenticity also affected women in Philadelphia who were going through the birth and postpartum phases of motherhood.

\textsuperscript{150} Ibid.

For example, Waters shared the account of a young woman who had been treated at a local hospital for a severe infection of the breast after delivering her infant a few days prior. The young woman was in acute pain from the infection and told the Triple Jeopardy activists that not only were the nurses withholding pain medication from her, one nurse in particular told her that because she was on public assistance, she should limit her requests for pain medication. The Triple Jeopardy activists organized a march outside of the hospital with several Black Panther Party members to protest this woman’s treatment. Waters recalls how, despite being one of the most vocal organizers and protesters at the event as well as the person holding the bullhorn, she was not arrested. Instead, the Black Panther men who were there only as a supportive presence, were taken into police headquarters and charged with civil disobedience. Their arrest was the result of the contentious history between Philadelphia police and the Black Panther men.

Waters became involved with the MCC as the result of the collaborative outreach by Joanne Fischer, a masters prepared social worker who had done field work with Dr. Walter Lear, Philadelphia’s Commissioner of Health. In 1973, Fischer, drove to Germantown to meet with Waters and her fellow activists at Triple Jeopardy. Fischer convinced Waters to join her in attending a meeting in Boston, Massachusetts to hear a talk by Dr. Helen Rodriguez-Trias, the founder of the Committee for Abortion Rights and Against Sterilization Abuse (CARASA). Fischer also convinced Waters to align Triple Jeopardy with her city-wide efforts to place marginalized women’s health needs in the

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152 Waters interview.
153 Dr. Helen Rodriguez-Trias was chief of pediatrics at Lincoln Hospital in New York City and actively opposed sterilization abuse for several years with the Committee to End Sterilization Abuse. Rodriguez-Trias was an outspoken advocate of and supporter of the Young Lords’ position that abortion rights needed to include access to comprehensive health care in order to be considered desirable to low-income women and Third World women.
center of the city of Philadelphia’s health department’s agenda. Like Waters, Fischer was also no stranger to protest marches. She and Lear attended peace marches protesting the Vietnam War as well as other social justice campaigns.154

**Conference on Women and Health in 1970s Philadelphia and the WHCC**

When the MCC was founded later in the 1980s, it was as a subcommittee of the Women’s Health Concerns Committee (WHCC), established in 1974. Significant to its foundation was the 1974 Conference on Women and Health, which advocated for greater communication between the state government and Pennsylvania’s women’s organizations.155 In the midst of the city’s political and racial unrest of the 1970s, the national push to recognize the unique concerns of women and women’s health gathered momentum in Philadelphia. On three consecutive days in June 1974, Temple University Law Center hosted the conference, which was organized by Fischer and co-sponsored by the Southeast Region of the Health Department and Commission on the Status of Women in cooperation with the Commonwealth of Pennsylvania’s governor, Milton Shapp. As Fischer remembers, “there was much hope in the state at the beginning of Shapp’s administration as governor of Pennsylvania.”156

Much of that hope in Governor Shapp was found in Shapp’s history as a Democrat who worked closely with both John F. Kennedy’s and Lyndon B. Johnson’s presidential campaigns. Shapp was also credited with the ideas behind the formation of the Peace Corps. Known as a consumer advocate as well as the innovator of successful

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155 Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.
programs for the elderly, Shapp was viewed as an ally to the concerns of women by activists in Philadelphia.

The issues identified by the speeches, testimony, and workshops at the conference fell into the thematic categories of access, quality, and control of health services. As a result of the conference, the Southeastern Region of the Pennsylvania Department of Health accepted the suggestions and initiated a working relationship with Fischer. She recalls that the energies generated from the conference birthed the women’s health movement in Philadelphia.\textsuperscript{157} The Women’s Health Concerns Committee (WHCC), chaired by Fischer, was a coalition of over 100 agencies, women’s groups, and advocacy groups that addressed a wide range of women’s health issues from the particular concerns with women’s mental health to the unique concerns of women prisoners.\textsuperscript{158}

The sentiment among Philadelphia’s activists was that women were an underserved and inappropriately treated group of consumers. The four purposes of the Conference on Women and Health were to raise public consciousness concerning women’s health care issues; to identify the needs of women as health care consumers for themselves and their families; to identify women’s roles as the providers of health care as

\textsuperscript{157} Staff from the cosponsoring agencies became the core of the Women and Health Planning Committee. This committee grew to over one hundred active people from organizations such as the National Organization for Women, CHOICE, Triple Jeopardy, the Health and Welfare Council, Planned Parenthood, Temple University, Girl Scouts, Hospital and Health Care Employees Union Local 1199, Pennsylvania Nurses Association, American Medical Women’s Association, YWCA, Coalition of Labor Union Women, and the public service media.

\textsuperscript{158} The collaborative energies from the conference drew support from political organizations such as The Political Committee of the People’s Fund. In a September 1974 draft, the group addressed themselves as an organization of individuals and groups working toward fundamental change in American Society. Calling themselves The People’s Fund, the group believed that American society is based on a system of economic relationships that require the exploitation of the majority of people in order to maintain the wealth, power, and influence of the few. The group sought to identify and support those groups in Philadelphia that share its analysis of the American system.
both professional and supportive workers; and to formulate actions and strategies for dealing with the problems faced by women as both consumers and providers.\textsuperscript{159}

A vital component of the conference was its intention to mobilize people to act on the problems identified and to channel them into existing organizations or interest groups concerned with and actively engaged in the issues of women and health. A panel of state legislators, administrators, and private health care providers and consumers heard testimony from twenty-eight witnesses on the first day of the conference. Ann Garland, Chairperson of the Philadelphia Steering Committee of the Regional Comprehensive Health Care Planning Agency, spoke on the role of community participation in influencing health the care system and urged women to become more involved in consumer-dominated health care planning agencies. The potential of self-help and organization of alternative health facilities such as feminist clinics was discussed by Dr. Mary Howell, Associate Dean of Harvard Medical School.\textsuperscript{160} Finally, Maggie Kuhn, co-founder and convener of the Gray Panthers, suggested that advocacy and coalition groups were necessary for making the health care system more responsive to the needs of people.

**Regionalized Perinatal Care**

In the five-year period leading up to the formation of the MCC, the WHCC collaborated with a number of national women’s health activist organizations in developing their strategic responses to the 1975 Robert Wood Johnson Foundation (RWJF) national demonstration programs for regionalized perinatal care.\textsuperscript{161} Based upon

\textsuperscript{159} Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.

\textsuperscript{160} Ibid.

\textsuperscript{161} Joanne Fischer participated in a November 2, 1977 conference sponsored by the Women’s Caucus of the American Public Health Association in Washington, DC. Fischer participated in a panel discussion
the recommendations of a group of physician leaders, the RWJF national regionalization project sought to reorganize the delivery of perinatal services in eight university medical centers across the United States and to evaluate the regionalized scheme. The major goals of this project were to monitor women during pregnancy; refer patients to appropriate facilities for prenatal care and delivery; and provide special facilities for high-risk women and newborns. The expectations were that quality of care would improve while reducing the unnecessary duplication of services would decrease costs.162 Yet many women’s groups, including the National Women’s Health Network (NWHN), the Boston Women’s Health Book Collective, along with the WHCC found it troubling that no other providers of women’s health care were included in the regionalization project planning efforts by Robert Wood Johnson.163

Largely concerned that a fully representative spectrum of women’s health concerns was not visible within this regionalization plan, WHCC prepared a needs statement to be incorporated into the Health Systems Plan of the Health Systems Agency of Southeastern Pennsylvania. The aim of the statement was achievement of a “delivery system that allows a full range of options, within a framework of high quality supportive, consumer controlled and family-oriented services.”164 Central to this delivery system, the activists pushed for the inclusion of nurse-midwives in the delivery systems. The WHCC

162 RWFJ National Demonstration Program, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML, University of Pennsylvania, Pennsylvania.
163 In a letter dated February 17, 1978, Judy Norsigian, a board member of NWHN wrote a letter advising the regionalization planners to include out-of-hospital maternity care in their project planning efforts. See WHCC, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML, University of Pennsylvania, Pennsylvania.
164 Ibid.
emphasized the importance of a woman-friendly conceptualization of four major areas of women’s health. The areas defined as most pressing were maternity care, family planning, mental health services, and the health needs of older women.\textsuperscript{165}

In terms of maternity care, the activists in the WHCC argued that pregnancy and childbirth were normal processes. They proposed that the quality of prenatal care, the health of the pregnant woman and her preparation for her birth held major influences on the progress and outcome of labor and birth. In a parallel fashion to national birth advocates, WHCC activists maintained that childbearing women should have control over their bodies and be fully informed of their options in prenatal care, labor, and birth. Significantly, they echoed national birth advocates’ passionate belief that midwifery services should be increasingly utilized for low risk women and that medical interventions in the process of labor and birth should be kept to a minimum. Finally, they proposed that specialized obstetrical procedures could be safely limited to the high-risk mother.

In 1978, the Health Systems Agency of Southeastern Pennsylvania’s (HSA) developed a working paper on obstetrical services and asserted that hospitals delivering less than 2000 births per year should be closed. The WHCC criticized this stance, arguing that the move would force low-risk mothers to be delivered in Level II or III facilities, which typically housed residency-training programs with their predominant over-use of medical interventions.

\textsuperscript{165} The focus of the dissertation is on maternity care. In terms of family planning, WHCC activists maintained that these services be available to individuals regardless of their age, race, marital or economic status. Informed choice was stressed with an emphasis on understanding how family planning works, its risks and benefits and alternatives. The WHCC activists also pushed for family planning and abortion coverage through public funds and third party payers. In a letter dated October 19, 1976, Joanne Wolf and her team engaged in the campaigning for then Presidential candidate Jimmy Carter. Citing his support of women’s issues, WHCC encouraged a high turnout of voter support for Jimmy Carter. See Women’s Health Concerns Committee, MS 588. Box 16, Folder 200 Women’s Health Collection, ARBML.
medical technologies in labor and birth for physician training purposes. In other words, the HSA working paper strongly pushed for low-risk women to be delivered in settings that were designed for high-risk care. As the WHCC activists argued, all pregnant women would be treated as high-risk cases with the resultant use of unnecessary medical technologies and limited birth options. Thus, in one of their statement papers, the activists argued for more options in childbearing for all women.166

The activists called for increased community health promotion and protection in the form of health education services. This call for education mirrored the national women’s health movement’s credo that knowledge of the body is power for women. Education, such as teaching women their options in labor and birth permeated the language of the activists. The activists strongly maintained that the lack of accessibility and continuity in existing prenatal care was the major factor contributing to certain groups of women becoming “high risk.” In addition, there was a strong push from the group to incorporate home birth as a respected and viable out-of-hospital alternative. The group also argued there should be more birth facilities located within women’s own neighborhoods instead of establishing high-risk birth facilities in several areas of the city.167

The turf battle for maternity care in Philadelphia officially began in 1978, when

166 Statement of the Women’s Health Concerns Committee, Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML. In another paper, entitled Comments on the Proposed National Guidelines for Health Planning, the WHCC activists also argued that the language in the proposed guidelines by The Committee on Perinatal Health did not clearly define the distinction between Level I units for “normal uncomplicated deliveries;” Level II units for “the full range of maternal and neonatal services, and Level III units for “all the serious types of maternal-fetal and neonatal illnesses and abnormalities.” The activists argued this type of guideline should be maintained as opposed to using the standard of 2000 births per year as informing regionalization.

the federal government announced guidelines for nationwide planning networks of health systems agencies. These guidelines specifically mandated that obstetrical services and neonatal intensive care services be planned and implemented on a regionalized basis.\textsuperscript{168}

The WHCC activists argued that care at the appropriate level should have been the key issue; however, utilization of beds and numbers of births predominated in decision making over the closure of obstetric units. Small hospitals fought to keep their obstetric services as several hospitals closed their units. Birth centers struggled for recognition.

In a terse 1980 letter of response to the Health Systems Agency, Dr. Kaighn Smith, Chairman of the Ad hoc Committee on Regionalization of Obstetric Services and the President of the Obstetrical Society of Philadelphia, reprimanded the group for even suggesting a focus on alternatives to maternity care. He built a case against the utilization of nurse-midwives, nurse clinicians, and nurse practitioners as ancillary care providers. He argued that these have not been shown to be “viable alternatives.”\textsuperscript{169}

Of particular interest to women’s health activists was the 1979 Surgeon General’s Report, \textit{Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention}. The priority goal related to obstetric care was to continue to improve infant health and, by 1990, to reduce the number of low-birth-weight infants. Yet, under the conservative policies of the 1980s, Congress slashed funding for human service

\textsuperscript{168} The Federal guidelines were highly influenced by a 1976 project: The Improved Pregnancy Outcome Project (IPO) initiated by the Office of Maternal and Child Health. Its goal was to reduce infant mortality by building statewide systems of care for mothers and infants through more effective utilization of existing services, and when necessary, through planning and implementation of new services. Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML, University of Pennsylvania, Pennsylvania.

\textsuperscript{169} Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.
programs. This period witnessed a dramatic decrease of funding for human service programs that greatly affected maternal child health services. Responsibility for resource allocation was shifted to the states in the new federalism. One of the mandates from this era was the Omnibus Budget Reconciliation Act. Under this act, seven of the federal programs were consolidated into a Maternal Child Health Block Title V Grant. The first of these programs went toward maternal child health funding. The Title V Block Grant funds were minimal compared to Medicaid. Title V and Medicaid laws required state agencies to develop inter-agency coordination agreements that addressed mutual objectives and responsibilities and the means by which they will be carried out, including coordination of plans for health service delivery, joint planning and joint evaluation. The two laws thus contemplated that the Title V agency would set standards and evaluate criteria that would be agreed to and carried out jointly by both Title V and Medicaid agencies.

In Philadelphia, as in other major cities, many state Title V agency officials were frequently mid-level bureaucrats with little, if any, control over the state maternal health budget or activities of the Medicaid agency. The WHCC saw this period as an opportunity to support nurse-midwives so that they could join committees and task forces, and challenge the state and Title V and Medicaid agencies to reconsider how and to whom they allocated funding. An additional challenge came in the early 1980s as an economic recession in the double digits affected some of the most vulnerable populations including children. For example, the total available Aid to Families with Dependent Children Program (AFDC) and food stamp benefits fell by 20 percent per poor child due
to government’s failure to adjust benefits to reflect the recession.  

Local Philadelphia activists were already discussing the city’s high infant mortality rates and how they envisioned meaningful change. The MCC was initiated as Philadelphia’s community-based and highly collaborative response to persistently high infant mortality rates plaguing the city’s marginalized women and communities. As Fisher recalls, MCC started as a conversation between Sparer Lear, and Sister Teresita Hinnegan. The combination of these three personalities and their professional backgrounds served as a powerful catalyst to the formation of the MCC.

**The Coalition: A Lawyer, a Doctor, and a Nun**

*Edward Sparer*

A 1959 graduate of Brooklyn Law School, Sparer was a pioneer in the fields of poverty and health law, and he had an inspiring career as a nationally recognized teacher, scholar, and activist. He was a founder of both the first neighborhood legal services program, Mobilization for Youth Legal Services in New York City and the first national support center for legal services work, the Columbia Center on Social Welfare Policy and Law. Sparer was "the intellectual architect of the legal strategy of the welfare rights movement."  

As a lawyer, Sparer continued his early commitment to community organizing. In representing welfare clients he encouraged creation of local welfare rights organizations that, in 1964, led to the creation of the National Welfare Rights Organization. He served

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170 See Sister Teresita Hinnegan personal papers. Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.
171 Fisher interview.
as general counsel to this group until his death in 1983. In 1970 Sparer created the Health Law Project at the University of Pennsylvania School of Law. The project, under the guidance of a board of directors, included doctors and sociologists as well as lawyers and represented health care consumers seeking access to high quality, affordable health care. It conducted empirical research, produced books and studies, and trained students in law, medicine, and sociology.

Walter Lear

An activist early in his life, Lear entered medical school during a time when Jewish and Black applicants were typically turned away. Lear soon found himself lobbying for racial equality in the medical profession. During the 1960s, he became inspired by the sit-ins and freedom rides as he continued to work for racial equality in the medical profession. From 1961 to 1963, he was a consultant for the National Urban League, doing research and writing that led to the publication of *Health Care and the Negro Population.* As noted in Chapter 2, Lear was a founding member of the Medical Committee for Human Rights (MCHR), and he worked with that organization while serving as Philadelphia’s Deputy Health Commissioner from 1964 to 1971.

Lear was an activist on several levels. In addition to health activism, he joined other physicians in the MCHR to protest the Vietnam War. During this same period, he became involved in movements to legally and politically gain equitable hospital access for African American patients and physicians. He and other physician activists realized the American Medical Association (AMA) was a major stumbling block in their stance

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towards Black physicians. Through their silence towards the topic of Black physicians being treated equitably; the AMA became a target for the MCHR’s activism and protest. For Lear, his career as a physician and his political activism were intertwined. In addition to his political activism, Lear was also proud of the fact that he was the first openly gay Commissioner of Health in Philadelphia. He worked tirelessly, often with backlash, towards the inclusion of homosexuals in all aspects of society.

*Sister Teresita Hinnegan*

Sister Teresita Hinnegan, Catholic sister, nurse-midwife, with a Master’s Degree in Social Work, was a University of Pennsylvania nursing instructor and health policy activist. As such, she was one of the most influential participants in this grassroots collective. Her life of social justice-related work served as a defining and vital component of her life commitment as a Catholic sister. Sister Teresita’s dedication to social movement work is an example of how deep religious identities can serve as pathways to continued participation in a wide range of activist actions.174 In an oral history interview, Sister Teresita shared some insight into what led her into her life work of advocating for women. From 1955 to 1969, Sister Teresita worked as a Medical Missions sister with the poor in Bangladesh. She came back to the United States to help her sister who was then alone with two children. It was then that she noticed, “how dysfunctional the system was for women with children to get the help they needed.”175 While helping her sister, she worked as a nurse-midwife in a Philadelphia community health center where she


witnessed the lack of health care resources for women living in poverty. These experiences influenced her decision to return to school for a Masters in Social Administration at Temple University. She stated, “I learned a lot, again, about the system and how dysfunctional it was and the change that was needed.” Sister Teresita combined her triad of professions – nursing, social work, and ministry – into a forceful tool for understanding and working for social justice.

Sister Teresita, Sparer, and Lear became the intellectual force behind the ideological and tactical beginnings of the Maternity Care Coalition in the 1980s. The three activists knew their struggle to reduce infant mortality in Philadelphia had to begin with a purposeful study of the area and the issues. Sister Teresita was given the important foundational role of organizing and conducting the study. Her detailed quantitative and qualitative analysis of Philadelphia’s areas of highest infant mortality told the story of a city’s failure at effectively providing care for its minority infants. (See Tables 2 and 3)

It also revealed persistent accounts of institutionalized racism as minority women were reportedly turned away from area hospitals if they could not pay a cash deposit before being admitted in labor to the hospital. The activists often had to use creative methods to expose acts of inequality in some of the area hospitals.

176 Ibid.
178 Catholic Sisters have a legacy of working against institutionalized racism. See Barbra Mann Wall, “Catholic Sister Nurses in Selma, Alabama, 1940-1972,” Advances in Nursing Science 32, no. 1 (2009). Khiara Bridges details her ethnographic study of institutionalized racism within a state sanctioned women’s health clinic in New York City. In Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization, Bridges argues that the Medicaid system frames pregnant, low-income, mostly minority women as pathology ridden possessors of unruly bodies requiring much state supervision and testing.
Sister Teresita and her cohort of fellow activists pretended to be low-income patients calling for obstetrical appointments. In one hospital’s case, the admitting clerks asked all the activists for pre-admission cash deposits of $1000. Eventually, with the evidence at hand, the hospital administration conceded this was in fact happening. In many cases, they were turned away due to not having insurance. The MCC activists, under the guidance of Sparer, introduced a lawsuit in 1984 against this hospital. They later settled this lawsuit when the hospital agreed to stop this illegal action.

One of the areas of her study that moved Sister Teresita greatly was the qualitative portion of the study. She and her cohort surveyed the streets of the two health districts talking to women there. Sister Teresita said the women had stories to share with the interviewers, stories of how they were treated by hospitals and clinics and how they felt. Many of the women shared that before the survey, no one really took the time to listen to them. Sister Teresita stated that one particular woman shared that she “felt like a slab of meat” in the hospital because no one looked upon her as though she was worthy of his or her attention. In a soft voice, Sister Teresita explained, “because nobody cared. Nobody cared.” Part of what Sister Teresita and her activists did was to bring these stories of institutionalized racism to city officials. Sister Teresita felt strongly that an important component of MCC’s activism was to help these women develop their

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179 Interview with Sister Teresita Hinnegan on November 19, 2007 by Linda Maldonado.
180 Sister Teresita interview.
181 Ibid.
182 Ibid.
own voices so they themselves could bring their stories forward as opposed to allowing
the inequities weigh them into submission.183

A Plan for the Provision of Maternity Services in Heath Districts 5 and 6

In 1978, Sister Teresita initiated a selective area analysis of Lower North Central
Philadelphia (Philadelphia Health Districts 5 and 6) to examine factors that held an effect
on pregnancy outcome. The study provided a comprehensive look at the two health
districts’ transportation access, racial compositions of the neighborhoods, number of
residential structures that were long term vacant, as well as the Capital Program Projects
for the areas. Sister Teresita looked at the sites for pregnancy testing and prenatal care,
the hospitals utilized for birth of a child by the women in the identified health districts as
well as the low-birth-weight statistics and infant death statistics.184

Another important component of the study was a survey of the hospitals women
from Health Districts 5 and 6 utilized for their obstetrical services. Sister Teresita asked
local neighborhood volunteers to perform one part of the survey. This component looked
at the hospitals in terms of their facilities and what they offered to patients such as
financial assistance, educational programs, translation services, the amount of sibling and
father involvement as well as rooming in and breast-feeding support for the women.
Women from Health Districts 5 and 6 completed the other component of the survey as
they gave their opinions on the services provided.

Sister Teresita found high numbers of women from the Health Districts received
inadequate prenatal care, experienced a high number and rate of low birth weight babies

183 Ibid.
184 Plan for the Provision of Maternity Services in Health Districts 5 and 6 (Lower North Central
Philadelphia). Personal papers of Sister Teresita Hinnegan, 4-6.
as well as a high rate of infant mortality. (See Table 2) The socioeconomic profile of the area indicated widespread poverty, high unemployment, and employment in low-paying dead-end jobs as well as low educational achievement. The housing profile indicated that people were living in environments that had been allowed to deteriorate and that attempts to rehabilitate the neighborhoods had been minimal.¹⁸⁵

Sister Teresita acknowledged in her study the causal relationship between poverty, social deprivation, low educational levels and the high incidence of both low birth weight babies and high infant mortality. A moderating influence in the situation was the presence and use of quality prenatal care programs. Many of the low-income women were not fully utilizing the prenatal services. On the other hand, the same services lacked the important outreach programs, support services, and inter-agency coordination that linked the pregnant woman with a continuum of care in her environment.¹⁸⁶

As a result of Sister Teresita’s study and the collaborative strength of MCC, city officials and hospital administrators were pressured into working to resolve the various issues surrounding Philadelphia’s infant mortality. The MCC and Sister Teresita worked intensively with Philadelphia’s communities of mostly minority and low-income women suffering tragically high rates of infant mortality.¹⁸⁷

**MCC Programs**

One of the primary objectives from the study was the establishment of a Planning

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¹⁸⁶ Ibid.
¹⁸⁷ Sister Teresita worked closely with various women’s health advocates such as University of Pennsylvania Professor of Law, Ed Sparer and Lotte Gottschlich, an assistant at the Health Law Project. Their collaboration initially worked to mobilize and develop the Maternity Care Coalition in the 1980s. Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.
and Coordinating Board of Maternity Care Programs in Health Districts 5 and 6 to include representatives from hospitals and freestanding centers offering pregnancy testing, family planning services, and prenatal care. An important outcome was a home visiting program, established in 1984, under the direction of Dorothy Jordan, MCC’s first paid advocate. Jordan was a former welfare recipient who MCC leaders invited to assume this important position. A trusted member of the local community, Jordan was viewed as a non-threatening black leader who had risen through the ranks of the Philadelphia NWRO.

The MCC had three key strategies. The first was the organization of a wide variety of professionals, lay community members, and other interested groups. The second involved holding both local and federal agencies directly involved in coordinating maternal-infant care accountable for improvements to care. Finally, a strong sense of commitment to the community and the seeking of community involvement were paramount and was the cornerstone of the MCC philosophy of practice.

**Community Coalitions**

Major emphasis was placed upon garnering community awareness of the Coalition and welcoming all manners of involvement. Some of the groups involved initially were the Philadelphia Welfare Rights Organization; Women’s Health Concerns Committee; CHOICE; Childbirth Education Association of Greater Philadelphia; Women’s Law Project; Health Law Project; Pennsylvania Chapter of the American
Another example of the collaborative style MCC embraced occurred during a June 29, 1982 meeting. The agenda for the meeting was to hold a discussion of a plan for maternity care from five perspectives: the Philadelphia Department of Health, the Obstetrical Society of Philadelphia, the Pediatric Society of Philadelphia, the Pennsylvania Chapter of the American College of Nursing, and the Philadelphia Perinatal Society. The community perspective of maternity care needs was also represented.

**Holding Hospitals Accountable**

In 1980, The MCC approached Hahnemann’s Ambulatory Health Network to engage in a planning effort and pilot project for delivering improved maternal and prenatal care within the Network. The desired outcome of this pilot project was to be a proposal for the network of hospitals with Maternal Infant Child Programs. In a letter from Welfare Rights Attorney Sparer to Dr. Forrest Lang, of Hahnemann Medical College and Chief of obstetric services there, Sparer requested the medical institution’s cooperation with the MCC. In a hint of what was to come, Lang shared that there were “other offers to perform this preliminary planning effort” and that he would bring the Coalition’s proposal to the nest staff meeting for discussion. Most important, Lang did agree to the use of certified nurse-midwives in performing the entire realm of maternity care for the network pregnancies.

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188 NWRO, MS 760. Box 48, Folder 599 Women’s Health Collection, ARBML.
189 Ibid.
Sparer responded in a June 20, 1980, letter to Lang. Sparer pointed out that the Coalition was comprised of city-wide consumer and consumer-oriented organizations with experience in and major concern for maternity care. The Coalition was not greatly concerned with who did the planning and implementation work – MCC or somebody else. Rather, it was “concerned only that it gets done, as promptly as possible.” Sparer expressed his hopes for the collaboration in the following closing to his letter: “I have a great sense of optimism that, with the Hahnemann Ambulatory Care Network and the Coalition working together, we can – in the near future – help save the lives and health of a great many infants and mothers. And, I believe, this can be – and is best – done in a way which not only involves the relevant communities, but helps make such important work the community’s own work.”

The group’s correspondence after Sparer’s response reveals they were already making alternate plans if Hahnemann did not accept their proposal. In fact, Hahnemann did not accept MCC’s proposal.

In 1984, MCC drafted a proposal to the Philadelphia network of hospitals with maternal child programs for financing of services for low-income women. First and foremost in the proposal was that every Maternal Infant Child delivery of service site should routinely advise new registrants that they will not be denied prenatal or in-hospital care even if they could not pay for the service. The proposal also called for in-service training sessions for clerks and financial staff to develop a sensitivity to the poor as well

190 Ibid.
191 Ibid.
192 Ibid.
as to thoroughly understand the regulations applying to low-income persons needing Medicaid or M.I.C. coverage for their care.

**Commitment to Community**

On the national level, MCC also attempted to bring the education of childbearing women into the spotlight. The MCC drafted a Public Advocates document that outlined a need to develop a national education campaign to inform women about the importance of early and comprehensive prenatal care and proper nutrition, about the risks during pregnancy of smoking, alcohol and the use of drugs, as well as the availability of publicly funded prenatal care and nutrition supplements. The document also encouraged state Medicaid agencies to use the current available options to expand coverage for pregnant women and infants, in particular, financially needy women in two-parent families, financially needy children, medically needy pregnant women and children, and women with first time pregnancies. Finally, the document pushed for the appointment of a Deputy Assistant Secretary for Maternal Child Health to coordinate all programs and funding sources serving low-income mothers and infants, including the establishment of a uniform definition of comprehensive prenatal care, the formulation of sound state plans, specific cooperative efforts between the state agencies administering Medicaid and the Maternal and Child Health Block Grants, the provisions for training and use of community outreach workers, and the maximum availability of nurse-midwives in accord with respective state professional practice laws.\(^{193}\)

The Public Advocates document was presented to the Secretary of Health and Human Services, Margaret M. Heckler, on June 29, 1983. Yet, as an MCC document

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\(^{193}\) Ibid.
reported, “instead of taking meaningful action, another commission was appointed.” The MCC agreed with Representative William H. Gray, Vice Chairman of the Congressional Black Caucus, who commented: “We are literally studying this issue to death – the needless deaths of thousands of Black and other low-income infants.”

Despite this setback, Sister Teresita focused her efforts on the ground in Philadelphia by educating those involved on the policies behind maternal-child issues. On September 23, 1983, she led a one-day conference in Philadelphia entitled “Maternal Child Health in the U.S. Today.” Sponsored by the Medical Mission Sisters, the conference introduced the concept of social justice and the childbearing woman as seen through the lens of federal and state funding of health programs for women and children. The conference addressed strategies necessary to close the gap between stated goals of legislation related to maternal child health and what was actually happening on the service level. The conference was open to the public and witnessed participants consisting of nurses, physicians, social workers, and others interested in the welfare of low-income women and children. By the end of the conference, many medical professionals had a better understanding of how legislative action worked at the service level.

Other work for maternity care persisted as well. In response to a request from the Congressional Black Caucus, the House Subcommittees on Health and Environment, chaired by Representative Henry Waxman (D-California), and on Oversight and Investigations, chaired by Representative John Dingell (D-Michigan), held a joint hearing on March 16, 1984, to assess the growing problem of Black infant mortality and the

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194 Public Advocates Document, MS 760. Box 45, Folder 571 Maternity Care Coalition Records, ARBML.
failure of the Reagan Administration to address the problem. Similar press conferences were being held in Los Angeles, New York City, Philadelphia, and San Francisco.

In March 1984, Pennsylvania Congressman William H. Gray addressed the dire situation in Philadelphia as it pertained to women and infants. “Without sufficient funding for improved prenatal and postnatal care, Philadelphia’s strategy to decrease the city’s high infant mortality will be severely threatened. Reagan’s budget cuts have had a devastating impact on the health care that low-income women and their infants receive,” Gray said.\footnote{195} Congressman Gray publically issued his support of Philadelphia Health Department and MCC’s initiatives to assist these women and infants.

Another activity of the MCC occurred on March 16, 1984, at a news conference at Hahnemann University Hospital. Walter Lear and Viola Sanders, co-chairpersons of the MCC, charged the U.S. Department of Health and Human Services with killing black infants in Philadelphia and throughout the nation by inaction on proposed improvements in federal programs that financed and regulate services for low-income pregnant women and infants.\footnote{196} They emphasized the continuing, shocking disparity between the death rates for non-white and white infants in Philadelphia (Table 1):

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-white</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>22.7</td>
<td>12.1</td>
</tr>
</tbody>
</table>

\footnote{195} Ibid.
\footnote{196} In an excerpt from the Public Advocates’ Administrative Petition on The Infant Mortality Gap in the U.S.A., they state that the Reagan administration was told three times in 1980, by the Comptroller General, the Surgeon General and Congress’ Select Panel for the Promotion of Child Health that the nation’s capacity to reduce the infant mortality rate and the social infant death gap was easily in grasp. Viola Sanders was a leader in the Philadelphia Welfare Rights Organization and a highly respected activist on community and social justice issues.
Lear and Sanders argued that Philadelphia’s figures strongly suggested that many of the non-white infant deaths were preventable. They also argued that one major contributor to this failure of the prevailing pattern of prenatal care was the policy of the current administration; instead of improvement, it had reduced federal funding of essential services and destroyed federal leadership and guidelines for creative approaches to the difficulties often faced by low-income, predominantly very young and non-white pregnant women.

**MCC, MOMobile, and Maternity Care Advocates**

The Black Panther Party’s health politics “serve the people” programs played a central role in MCC’s organizational activities.¹⁹⁷ Attention to community service was an expression of Panther commitment to their ideologies and practice in response to their frustrations with what they deemed black cultural nationalists’ preoccupation with rhetoric and the limitations of the War on Poverty programs. The Black Panthers also successfully employed outreach tactics utilizing mobile health vans. Some of these mobile health vans were old ambulances.¹⁹⁸ Indeed, one of the most effective programs of outreach developed by MCC was the Mom-mobile and the Latina Mom-mobile. Much of the MCC’s success was attributed to the community advocates who staffed the bright yellow vans where pregnant women could get blood pressure checks, assistance in enrolling in prenatal care, Medicaid, Food Stamps, and other relevant programs. The

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¹⁹⁸ Ibid.
MCC also employed “Maternity Care Advocates,” members of the community who held a position of trust and respect within the neighborhood. In addition to finding pregnant women who were not enrolled in prenatal care, these advocates also tried to locate and assist homeless and addicted pregnant women.199

These community advocates were usually older women who resided in the same low-income neighborhoods as well as minority women who had experiential knowledge of the loss of an infant. The notion of utilizing community members towards health promotion is a powerful idea that other groups such as the Black Panthers employed with great success. Staffed also with medical assistants, this unique outreach program brought a new kind of health promotion with services such as pregnancy testing and subsequent linkage to prenatal care for low-income women in their neighborhoods.200 In addition to prenatal health promotion, MCC played a crucial role in low-income women’s increasing sense of empowerment through various social support programs such as classes on consumer rights in health care and how to navigate hospital system barriers.

The MCC’s techniques of fostering communities’ invested ownership over health issues were also influenced by Black Panther ideologies of health activism. Waters detailed how she and other black women from her 1970s organization, Triple Jeopardy, collaborated with MCC and brought many of the Panther ideologies such as care by the community for the community into MCC. The MCC also supported other minority groups organizing for improved living conditions and health care such as the growing Asian community in Philadelphia. The Yellow Seeds formed in the late 1970s was

199 Mom-mobile, MS 760. Box 45, Folder 400, Maternity Care Coalition Records, ARBML.
200 Women’s Health Concerns Committee, MS 588. Box 20, Folder 284 Women’s Health Collection, ARBML.
comprised of Asian Americans living in Philadelphia and modeled their activism in some parallel fashion to the Black Panthers and other Black Power organizations.

_The Philadelphia Welfare Rights Organization_

One of the MCC’s most powerfully effective on-the-ground activities was its alliance with the Philadelphia Welfare Rights Organization. As noted above, Dorothy Jordan became an advocate to the women in the communities MCC served. Jordan rose in the ranks of the Welfare Rights Organization initially by being asked to take over a class on welfare rights in which she was an attendee. In her words, she shared, "my training started on the ground and never looked back."²⁰¹ Eventually, Jordan became involved with the MCC as an advocate. Her role included counseling women who missed prenatal appointments; searching in the communities for women who missed appointments; recruiting pregnant women into prenatal care; and assisting these women obtain necessary social services such as food stamps, Women Infant and Children (WIC) assistance, and other forms of social support. Eventually the MCC and Philadelphia Welfare Rights parted ways as in Jordan’s words, the “MCC was not into jumping on tables, shouting and demanding action for welfare mothers like some of the leadership in the Philadelphia NWRO. The MCC way of doing things was to talk more and come to solutions.”²⁰² When asked why she stayed with the MCC, Jordan replied that she felt they were “doing things differently but effectively. There wasn’t just one way to get change.”²⁰³

²⁰¹ Interview with Dorothy Jordan on December 1, 2012, by Linda Maldonado.
²⁰² Jordan interview.
²⁰³ Ibid.
Maternity care advocates such as Jordan were mature and trusted women from the affected communities who contributed greatly to MCC’s vision of bringing the community into awareness of maternal-child health. These women, who knew their neighborhood well, would canvass the area for pregnant women and give them MCC educational materials as well as encouragement to seek health services. The client advocacy project helped 131 clients between July and November 1984 and was funded the most part of the Henry Tower Wurts Memorial. They received a grant of $2500. The money was spent for a Client Advocate/Educator, Jordan, and transportation for the advocate. In December 1984, MCC launched their Community-Based Home/Family Visitor (CHV) program. The program targeted pregnant women who lived in the two health districts 5 and 6. It also targeted all mothers and their newborn babies. The program was designed to meet a thorough health education of the pregnant woman and her family to include health education, fetal development education, plans for delivery and preparations for the baby. A vital part of this outreach was referrals when necessary for food, housing, fuel, and transportation. Active listening to the women was also an outlet for problems that could be related to other providers for intervention.204

For new mothers and infants, the program also provided health education with infant growth and development as well as guidance about feeding patterns, weight gain and general infant care. The CHV also ensured follow-up with both the mother’s and the infant’s providers. The Philadelphia Department of Health assumed the responsibility of the program. The CHV accompanied the public health nurse or certified nurse-midwife in

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204 CHV Program, MS 760. Box 45, Folder 568 Maternity Care Coalition Records, ARBML.
their assessment of the mother and baby. So a close working relationship between the community and the professional was established. Home visits were to continue until the infant was one year of age.

The activists in MCC broadly conceived health promotion in the community. In addition to their operations involving the dissemination of education and health promotion to the affected communities, MCC also held many social events. Massage therapy events, facials, Mother’s Day celebrations, as well as holiday parties marked just a few of the social and community building types of activities MCC embraced. The MCC advocates also involved the partners of the women in the community. Many of their events focused on the men in the women’s lives as well as educational programs designed especially for the concerns and educational needs of the men.

This chapter has detailed an important and generally overlooked part of the women’s health movement of the 1970s and 1980s: the coalition of midwives, physicians, social workers, and local community members that comprised the MCC in Philadelphia. The activism in which this coalition engaged involved networking with individuals and groups interested in reducing infant mortality as well as direct engagement with the affected communities. The MCC leadership, such as Fisher, actively recruited members of various organizations to join the MCC’s efforts. The active involvement of organizations such as Triple Jeopardy with its links to the Black Panthers sheds light onto the style of radical activism that MCC employed.

With members such as Sister Teresita, Sparer, and Lear, the activism that MCC employed represented a very wide spectrum of styles from activities that were not necessarily viewed as disruptive to those that directly challenged some of the power
players in health care administration. The MCC, in addition to advocating for low-income women to receive decent obstetrical care, also took part in political campaigns that considered other aspects of women’s health through a feminist lens.

For example, the MCC and its affiliate, the Women’s Health Care Coalition, lent time and support to DES mothers and children as well as campaigned for officials who advocated for a woman-friendly platform.\(^{205}\) The MCC activists participated with The Philadelphia Women’s Action Coalition and the Women Organized Against Rape (WOAR) campaigns going on in Philadelphia during the 1970s and 1980s.\(^{206}\) Under Fisher’s guidance, the politicization of MCC became known for a wide variety of women’s health causes.

Fisher also led the organization in the area of safe abortion access. Organizations such as the National Organization of Women (NOW) lent support to the MCC. The MCC did align itself with other coalitions in Philadelphia, advocating for safe, accessible abortion services for all women. Despite her religious identification as a Catholic Medical Missions Sister who followed Catholic teachings about the right to life, Sister Teresita still worked with the MCC in her fight to help women access equitable obstetrical care.

In one of its more radical moves, Fisher and other MCC activists pushed for the legalization of prostitution in Philadelphia and Pennsylvania. In a June 29, 1976, meeting and panel discussion, Fisher introduced a meeting of the Philadelphia chapter of

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\(^{205}\) In a 1976 Burlington County Times magazine article, “Living With a Time Bomb,” the author discusses how the daughters of women who took diethylstilbestrol (DES) live with the fear they will develop cancer. The DES Action Group in Philadelphia held meetings at the Friends Meeting House for concerned women and others to garner support for their questions and concerns. DES Action Group, MS 760. Box 19, Folder 249 Women’s Health Collection, ARBML.

\(^{206}\) DES Papers, MS 760. Box 19, Folder 252 Women’s Health Collection, ARBML.
COYOTE. The acronym stood for Call Off Your Tired Old Ethics. In a panel discussion, they discussed the decriminalization of prostitution. In a 1976 letter to William Eckensberegger, Chairman of the Pennsylvania House of Representatives, Fischer pushed for the decriminalization of prostitution citing the inequities that low-income, minority female prostitute faced in the streets of Philadelphia. Some of the identified inequities included the women getting arrested but not their male customers, as well as poor women being harassed on the street but not women who were protected by wealthy backers. Despite the decriminalization of prostitution not becoming a reality, the MCC activists were undeterred.

The next chapter looks at Ruth Lubic and the Maternity Center Association. With an entirely different history as well as a different style of activism and mobilization, the chapter adds to the rich tapestry of social movement styles that the 1970s and 1980s witnessed.

(Tables were copied, with permission, from Sister Teresita Hinnigan papers.)

Chapter Four

The Maternity Center Association, New York City

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207 Ibid.
In further examining nursing advocacy as well as the advocates’ perception of their own work, this chapter focuses on the Maternity Care Association (MCA) in New York City and the work of Ruth Watson Lubic. New York City’s MCA has a longer history than MCC, since it was founded in the early 1900s as a Progressive Era response to both Manhattan’s and the nation’s growing issues with maternal and infant
mortality. The MCA pioneered an agenda for women and infants through several
trendsetting ways. In the 1930s, the Lobenstine Clinic and School opened as the first in
the nation to educate “a new and uniquely American practitioner –
the nurse-midwife.” In the mid to late 1940s, MCA responded to post war prosperity
and decline in infant and maternal deaths through a new venue. By advocating for birth as
a more satisfying event for the entire family, MCA became one of the initial proponents
of the natural birth movement.

The MCA’s most influential director in the post war period was nurse-midwife,
Dr. Ruth Watson Lubic. In her twenty-five years as MCA’s General Director (1970 –
1995), she became a major force in transforming health care for childbearing women and
their families. Lubic championed the birth center movement by initially advocating for
women to deliver in an out-of-hospital setting. In 1975, her famous East 92nd Street out-
of-hospital Childbearing Center (CbC) opened. This was not the first birthing center run
by midwives in the U.S., however. While Mary Breckenridge’s Frontier Nursing Service
had begun services in women’s homes in the 1930s in Kentucky, Sister Teresita
Hinnegan’s Medical Mission Sisters established a birthing center in Santa Fe, New
Mexico, in the 1940s. Like its predecessors, Lubic’s birth center challenged the business
of hospital birth with its documented over use of medical technology, hypnotic drugs, and
controlled environments. Lubic’s out-of-hospital birth option came at a most opportune
time during the women’s health movement as women’s health activists increasingly

208 Maternity Center Association Records, Archives & Special Collections, Augustus C. Long Health
Sciences Library, Columbia University, New York (hereafter cited as MCA).
209 “Lobenstine: The Only School for Nurse-Midwives in the United States,” Box 1, Folder 9, MCA.
challenged prevailing medical ideologies of patient passivity and medical control. Women’s health activists emphasized the need for humane practitioners in settings that allowed women to retain their values, especially those related to autonomy and control during childbirth.

Unlike the MCC, with its more radical roots in the 1960s in the person of Walter Lear and groups such as the Black Panthers, the MCA was influenced by success from the East 92nd Street CbC, patronized by mostly middle and high-income women and their families. However, similar to other women’s health organizations in the 1970s, Lubic was interested in changing the stereotype of pregnant low-income women consistently classified as high-risk pregnancies. As Julie Fairman explains, many of these women had histories of “bad outcomes” not because they were high risk but because of issues with social support. In addition, many women in this context did not have access to consistent prenatal care or proper nutrition. These factors, especially when combined, were positively correlated to preterm birth and low-birth-weight deliveries, both of which

210 The feminist influence on birth was highly visible during this period as feminists became wary of anything sanctioned by physicians. Many middle-class educated women who had read Thank You, Dr. Lamaze, questioned the famous Lamaze form of controlled breathing. The controlled breathing advocated in the Lamaze way of childbirth hearkened to the patriarchal control many of these women were avoiding in their personal childbirth experiences. Wendy Kline, Bodies of Knowledge: Sexuality, Reproduction, and Women’s Health in the Second Wave (Chicago: The University of Chicago Press, 2010). Throughout the 1970s, the consumer push for demedicalized childbirth grew as both nurse-midwives and hospitals took note. Elizabeth Mitchell Armstrong and Eugene Declerq detail how hospital maternity units responded to the consumer push by creating birthing suites that cleverly concealed medical equipment and other new technologies such as the fetal monitor behind quilts, and other accoutrements meant to invoke the comforts of home. In the 1980s and 1990s, a large percentage of women and their partners embraced these amenities even as obstetrics embraced more technologies that pushed maternity care back in the direction of medicalization. See Armstrong, Elizabeth Mitchell and Declerq, Eugene. “Is it Time to Push Yet? The Challenges to Advocacy in U.S. Childbirth,” in Patients as Policy Actors, eds. Beatrix Hoffman, et al., (New Brunswick: Rutgers University Press, 2011).
Thus, Lubic’s next center was strategically placed in a poor neighborhood in the southwest Bronx. Both centers modeled how midwifery-led birth centers could drastically reduce Cesarean section rates, lower rates of preterm birth and low-birth weight neonates within low-income, minority communities. Interestingly, despite saving the cities millions of dollars by improving outcomes, Lubic still faced opposition from certain physician groups. In addition, much of Lubic’s time was spent lobbying in order to raise funds to cover considerable birth center operational costs.

The life history of Lubic as procured through archival research, oral histories, secondary sources, and interviews with Lubic herself, offers a powerful glimpse into one woman’s interpretation of nursing as well as an example of the opportunities and obstacles women faced when stepping outside traditional boundaries of gendered work. Lubic’s version of nursing is one heavily entrenched in midwifery care that started with her initial involvement with the MCA in New York City and continues with her current DC Developing Families Center (DFC) that houses her Family Health and Birth Center. This chapter focuses primarily on the MCA and the tensions involved in its operations in the 1970s and 1980s, and an Epilogue describes Lubic’s current work in Washington, D.C. Lubic is often referred to as an activist for women and children. She, on the other hand, rebuffs the term activist as a self-descriptor and instead offers up the

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212 Interview with Ruth Watson Lubic on June 24, 2009, by Linda Maldonado.
213 A nurse-midwife is a registered nurse who has gone for graduate level education in midwifery. A literature search shows many different models of care given by midwives. In most of the models, the expectant mother and her needs are given central concern.
statement: “I never thought of myself as an activist. I just always felt like families deserve this type of care.”

The unease Lubic has with accepting the activist descriptor is also reflective of a larger and broader societal understanding of nurses and nursing. As argued previously, nurses have been largely invisible in prominent literature on the larger women’s health movement occurring in the late twentieth century U.S. Morgen and Wiseman either omit nurses completely from the conversation of the women’s health movement or portray the contributions of nurse practitioners and certified nurse-midwives as minimal. Indeed, the relationship between nursing and activism is historically complex and heavily dependent upon the individual nurse or groups of nurses and the larger sociopolitical context where they are nested. As Lubic’s story shows, it is important toward the development of an understanding of nursing activism to unpack the ways in which ordinary nurses consider the social and political implications of their own actions.

Lubic’s contributions to nursing and midwifery have been widely described through various sources such as interviews for articles in nursing, public health journals, as well as the CBS news. I have relied on these sources as well as personal interviews with Lubic, an associate, and archival data on the MCA. In order to understand Lubic’s involvement with MCA, I will first examine the context of Lubic’s formative years and early career. The latter sections then examine her involvement with the MCA.

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214 Lubic interview.


216 See Stuart concerning the reframing of activism through the lens of nursing and social action. Meryn Stuart, Guest Editor’s Note in Nursing History Review 2010, (2010): 81-83. The article discusses how nurses such as Lillian Wald and the Henry Street Settlement did not see themselves as radicals but as reformers. Nonetheless, Wald agitated for change inside the system with her powerful networks.
Early Influences on a Nurse Activist

As Fairman argues, nursing activism often results from the intersection of powerful individuals working at the grassroots level to produce a larger activist movement. Lubic’s work is such an example.217 The second of two children of John Russell Watson and Lillian (Kraft) Watson, Lubic was born Ruth Watson on January 18, 1927, in Bristol, Pennsylvania. Her father, a pharmacist, owned a drugstore, which he managed with the assistance of his wife. After the onset of the Depression, many townspeople and area farmers became too poor to pay for the services of a physician, and they would come to “Doc” Watson with their medical problems. He gave many of them pharmaceuticals on credit and often had to take out loans to replenish his stock. “If you were sick and needy, he tried to help.”218

Other people who influenced Lubic during her early years were Dr. Fox, the Watson family doctor and her Aunt Alice. Dr. Fox, Lubic recalls, not only cared for the family’s physical ills but also encouraged Lubic and her sister’s intellectual and cultural growth. Aunt Alice, another wise woman and entrepreneur in nursing before her time, was a nurse who owned and ran a “school of rhythm.” The school specialized in “enhancing body mechanics and teaching stress reduction” through the use of music and an emphasis on the “spiritual aspects of body movement.” Lubic believes that, without conscious awareness of it, she internalized her aunt’s conviction that “the overuse of machines in the treatment of the sick interfered with normal physiologic processes.”219

217 Fairman, “‘Go to Ruth’s House’, 118-129.
In 1952, at age 25, having saved enough money to cover tuition and expenses and following Aunt Alice’s directions, she entered the School of Nursing at the Hospital of the University of Pennsylvania. As required of all nursing students at the time, Lubic spent 44 hours each week on duty at the hospital. In her tour as the evening charge nurse on a surgical ward, she ministered to patients who had undergone serious operations just hours before. Today, under policies now considered standard, these patients would have remained in recovery rooms or intensive-care units. “I marvel that I didn’t run in terror,” she has said. She served as student-body president and sought (to no avail) for a reduction in the workweek from 44 hours to 40 hours. She also digressed from the norm when, a few weeks before graduation, she married William Lubic, a recent graduate of the University of Pennsylvania Law School. Lubic’s marriage was, in a sense, an example of her independent thinking since most schools of nursing at that time did not admit women who were married or pregnant.

Looking back, Lubic recalls that there was a richness and complexity to the nursing experiences that raised an important question in her mind: “I pondered on the militaristic way of nursing and why our ability to follow directions was so important, rather than thinking for ourselves.” The answers to these questions posed by Lubic would coalesce within the professional and enduring match between midwifery and a young Lubic. The defining opportunities in Lubic’s formative years helped lay an important foundation for her growth as a leader and visionary. Life thus far taught Lubic how to lead while caring for others in tandem.

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221 Baer, “Trendsetter.”
From 1955 to 1958, Lubic worked at the Memorial Center for Cancer and Allied Diseases (now known as the Memorial Sloan-Kettering Center) in New York City, where she eventually became a head nurse. At night, she took courses at Hunter College, with the goal of getting a B.S. degree in nursing. She earned that degree in 1959 with a scholarship from the Teachers College of Columbia University. In June 1959, after four years of marriage and two weeks after her graduation, she gave birth to her son. Her husband witnessed the event, thanks to her obstetrician, who, in an action highly unusual for the time, made it possible for him to be present in the delivery room and to remain there with her and their newborn for an hour after the birth. “The three of us bonded, and to this day, we are close emotionally, if not geographically.”

Lubic’s own birth experience contrasted sharply with many of the maternity patients she served during her training. Often treated with condescension and insensitivity by their doctors, they typically traveled through pregnancy and birth ill-informed and ill-prepared. Some months after becoming a mother, Lubic confessed to her obstetrician that although she had begun working towards a master’s degree at Teachers College in medical surgical nursing education, she thought she could “make the best use” of herself in maternity nursing. He advised her to enter the field of midwifery. “What’s that?” she asked him. Her unfamiliarity with the profession served as a reflection of the scarce number of midwives on the American scene at that time.

222 Lubic, “Insights from Life in the Trenches,” 64.
223 Ibid.
224 Until the 1900s nearly all births took place at home with lay midwives in attendance. By the middle of the twentieth century, obstetricians in hospitals delivered almost all babies. GI health insurance during World War II covered only hospital births, and for many years after the war virtually every American hospital excluded midwives. In addition, an important shift was taking place in the culture of American birth. Expectant parents viewed the hospital as a “safer” place to deliver. Newspapers touted the extensive
Lubic applied to the certificate program in nurse-midwifery at the MCA. Organized and operated by women throughout its history, the MCA came into existence in 1918, during a period when the maternal mortality rate in the United States reportedly exceeded that in any other developed country. It was founded as a nonprofit health agency dedicated to the advancement of education about childbearing and to the improvement of the care given to women during pregnancy and birth and after delivery. The majority of women who were targeted for this organization’s efforts were the urban and rural poor. Its prenatal clinics were the first such facilities in New York City, and its classes for expectant parents are believed to be the first to be offered anywhere. Within a year of its opening, the MCA had accumulated ample evidence showing that good care significantly reduced maternal and infant mortality. In 1931, it launched a nationwide educational campaign to inform the public about the importance of maternity care, and it also established a school of nurse-midwifery, the first such institution in the United States.

A 1956 editorial in the *American Journal of Obstetrics and Gynecology* reveals that there was some physician support for midwifery training based upon MCA’s positive reputation of educating and training midwives. The author, Dr. Herbert Thomas, speaks


225 The Children’s Bureau, formed in 1912, promoted each state to perform birth registration as a means of attacking infant mortality. Prior to that, states relied on local efforts to collect this data. In order to encourage registration, the Children’s Bureau mobilized the resources of the national women’s clubs, which formed hundreds of committees to urge physicians and mothers to be certain that births were registered.

226 “Lobenstine: The Only School for Nurse-Midwives in the United States,” Box 1, Folder 9, MCA.
of a “continuing shortage of doctors” and “more than four million women who will need obstetrical care in the next and in succeeding year.”

He poses the question of who is going to deliver this number of babies and “how adequate is the maternal care going to be?”

Thomas cites a study conducted by Dr. Eastman at the Johns Hopkins University Hospital. The study showed that midwives working in collaboration with obstetricians could take “excellent care of women throughout pregnancy, labor, and the puerperium.”

Eastman’s quote in the article revealed his stance on the role and benefit of the trained nurse-midwife: “I have watched all this with my own eyes and am convinced that the meticulous type of care they give is the answer to the greatest weakness in American obstetrics, lack of emotional support both in pregnancy and labor.”

Lubic’s experience with physician support approximately two decades later with the initiation of MCA’s Childbearing Center would expose yet another side of physician sentiment on the issue of midwives and the passionate call Eastman issued in the 1950s.

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227 Herbert Thomas, “A Wider Outlook in Obstetrics,” *American Journal of Obstetrics and Gynecology* 72, no. 6 (1956) 1305. Johns Hopkins University Hospital, Box 4, Folder 3, MCA.

228 Ibid, 1305.

229 Ibid. Eastman’s convictions arose from an experiment that was set up at John Hopkins Hospital in 1953 for three purposes. Those purposes were (a) to study the feasibility of training nurse-midwives in a university obstetric clinic; (b) to evaluate the specific contributions that well-trained nurse-midwives can make to maternity care; and (c) to ascertain the role that nurses so trained can most advantageously play on the “obstetric team.” The program was organized and carried through by nurse-midwives trained at the Maternity Center Association. The student nurses under the training of MCA midwives were known as Obstetric Assistants. Under “medical supervision,” the Obstetric Assistants assumed complete responsibility for antenatal, intrapartal, and postpartum care of the women who were assigned to them. The Obstetric Assistants cared for the laboring mother, giving support, nursing care, and “carrying out orders for medications and treatment within the limitations of the standing orders.” The delivery of the baby and the responsibility of the mother and baby during the immediate postpartum period were assumed by the Obstetric Assistants. In addition to the physical care provided, the assistants gave mothers instruction in postpartum exercises, care of the baby, and adjustment of the family to the new baby.

230 Ibid.
Lubic entered MCA’s certificate program in 1961. With more than 7,000 births a year, its obstetrical service was one of the busiest in the nation. Lubic said that among the most valuable lessons she learned there was the importance of listening to and involving the whole family in decision making about care, rather than having them stand by as passive recipients. She earned a certificate from MCA and the State University of New York in 1962. Upon completion of her nurse-midwifery education, Lubic immediately became an active participant in her professional organization by becoming the 331st member of the small but active American College of Nurse-Midwifery (ACNM). By the end of the year, Lubic was a member of the Program Committee and a year later became the Chair of Local Chapters. Involvement in her community of peers was rapid and Lubic was elected vice-president of the ACNM in 1964.231

Leadership in Training

Lubic’s leadership qualities, goal-directed philosophy, and innovative thinking were valued by nurse-midwives throughout the country, evident by her being chosen president-elect of the American College of Nurse-Midwives in 1969. The term of office as president was to begin two years later, but Lubic’s practice and teaching of nurse-midwifery at MCA led her to other choices and challenges. During this period, Lubic taught nursing at the Graduate School of Nursing at New York Medical College and nurse-midwifery at the MCA.

Between 1963 and 1967, she worked as an MCA parent educator and counselor, a job in which she enjoyed seeing “apprehensive expectant couples change into confident families.” Her satisfaction was tempered by the realization that her limited knowledge of

231 Baer, “Trendsetter.”
different cultures was preventing her from responding adequately to the needs of some of her clients. Part of her early training as a midwife in MCA’s certificate program, Lubic participated in home visits to post-partum women 24-hours post-delivery. Lubic recalled her home visit to a Puerto Rican young mother in East Harlem. Since the national push to breastfeeding was not a priority in the 1960s, mothers were routinely taught how to prepare formula to feed their infants before hospital discharge. The infant formula at the time consisted of water, Karo syrup, and evaporated milk. Women were taught to make the formula then sterilize the bottles on a stove. As Lubic recalled, for women who hardly spoke English and who did not have adequate income, these tasks could seem overwhelming and confusing.232

Upon entering the young Puerto Rican woman’s apartment, Lubic quickly noticed the two-day-old infant in distress. “I was trying to figure out what was wrong,” she recalled. I could speak a little Spanish, but not a great deal. You know I was trying to figure out what this woman was feeding the baby. Because it quickly became apparent that there was nothing in the baby’s diaper and its little anus was bulging. So, it was all impacted, you know? And because her culture told her that you do not give babies things in cans, because canned food is “hot,” not temperature wise, but culturally, it’s “hot.”233 So she could not give the baby the formula she had been taught to make because it was against her culture. So what she was doing was going to the grocery store and buying milk out of the case and taking it home and putting it in a bottle and heating it…to give to

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232 Lubic interview. Bottle-feeding during this time was viewed as an answer to women’s desire for freedom and the ability to return to work early. Educated women were especially eager to bottle feed as breast-feeding was symbolic of low social status.

the baby. And of course, babies can’t digest cow’s milk protein! So, that’s what made me decide it’s time for me to study anthropology.”

When Lubic went to Teachers College for applied anthropology in the late 1960s, she believed she was going to do a dissertation for health care professionals to “teach them that they needed to be sensitive to the cultures of the people they were going to serve: that they could not press their own culture on them. Also in those days, in my experience, the African American would say yes to anything you said to do. You know, they would just, yes, yes ma’am. Yes, yes, yes and you never knew whether they did understand or not.” Lubic’s frustration in understanding the communication styles of different groups of maternity patients could have also been a reflection of issues of mistrust minority groups held in communicating with white professionals. Lubic employed different mechanisms to gain trust when working with communities of color later in her professional career.

Lubic’s professional advancement into the role of MCA’s general director in March 1970 inspired her to rethink her professional direction and dissertation topic. As noted in Chapter 2, the 1970s witnessed feminist groups and women’s health advocates challenging any and all patriarchal influences and unnecessary medical interventions surrounding birth. During this period, expectant feminist mothers and their support systems became wary of anything sanctioned by physicians. Many middle-class educated women who had read Thank You, Dr. Lamaze, questioned the famous Lamaze form of

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234 Lubic interview.
235 Ibid.
controlled breathing. The controlled breathing advocated in the Lamaze way of childbirth hearkened to the patriarchal control many of these women were avoiding in their personal childbirth experiences. Throughout the 1970s, the consumer push for demedicalized childbirth grew as both nurse midwives and hospitals took note.

Books such as Suzanne Arms’ *Immaculate Deception: A New Look at Women and Childbirth in America* became a *New York Times* bestseller in 1975 during the feminist firestorm over the American way of birth. Brimming with accounts from women who experienced dissatisfying birth in hospital systems, Arms’ book became one that women quickly shared with one another. Arms’ chapters on U.S. infant mortality statistics and the over-use of unnecessary medical interventions added to the firestorm of critique over obstetrician assisted birth for low risk women while simultaneously gaining support for midwives.

Despite a seeming nod of approval for all midwives, another issue was brought to the surface in Arms’ book that drew a closer look into the term “midwife.” In addition to expectant feminist mothers and their support systems becoming wary of anything sanctioned by physicians, they simultaneously became suspicious of any profession deemed under the control of the medical umbrella. The nursing profession and nurse-midwives fell under that umbrella. Arms discusses Lubic in Chapter Four of her book, citing Lubic as an example of a “small core of liberals who have begun to fight for the

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237 Arms, *Immaculate Deception*.
238 Examples of some unnecessary medical interventions in birth cited by both feminists and women’s health activists were the routine use of fetal monitors, routine episiotomies, unnecessary cesarean sections, and not allowing women to freely ambulate in labor.
239 A nurse-midwife is a registered nurse with a Master’s Degree in midwifery training. A midwife or lay-midwife refers to a person who practices midwifery without a nursing degree.
recognition of nurse-midwifery as a separate entity from nursing and the obstetric staff.\textsuperscript{240} However, Arms then goes on to critique Lubic’s position by arguing that nurse-midwives have carved a “sticky” position for themselves as they separate from staff nurses and yet are not entirely accepted as colleagues by physicians either. Arms concludes that a nurse-midwife can “never be an independent practitioner.”\textsuperscript{241} This quote and the sentiment represented within it revealed a portion of the opposition Lubic received with her stance that midwives should be trained registered nurses before going on to a midwifery degree. As Lubic shared with me, her beliefs at times conflicted with those around her: “I had to distance myself from several organizations that felt lay-midwives were an acceptable provider of maternity care.”\textsuperscript{242} As a professional nurse-midwife, she felt little sense of connection with these lay practitioners.

In March 1970, Lubic was named the general director of the MCA. She assumed that position during a period when growing numbers of young American childbearing couples were becoming more knowledgeable about themselves, their reproductive systems, and healthcare. She did not lead alone.

\textit{Tensions with New Leadership}

Soon after she began directing the MCA, Lubic and the MCA board began to move ahead with plans to open a freestanding birth center as a pilot program with MCA. Phyllis Farley, Lubic’s longtime friend and head of the MCA Board of Directors,

\begin{itemize}
  \item[\textsuperscript{240}] Arms, \textit{Immaculate Deception}. 157.
  \item[\textsuperscript{241}] Ibid, 159. The issue of midwifery training (lay-midwife versus nurse-midwife) is one that continues to strain the practice of midwifery today. Lubic believes that midwives need to be trained nurses before they can be effective nurse-midwives.
  \item[\textsuperscript{242}] Lubic Interview.
\end{itemize}
remembers spending “more time on the train heading to Albany” than doing most other things as she and Lubic petitioned to obtain licensure for their freestanding birth center innovation. Lubic’s MCA lay Board of Directors (as opposed to the Medical Board of MCA) was pivotal to her success at MCA. Historically, the MCA’s Board of Directors was almost always comprised of women from New York City’s upper classes. These women came from families who were long-time philanthropists. As Farley recalled, she was brought up with “a theory that if you were lucky enough to be born in a certain fashion, then you had an obligation to your community.”

The men on MCA’s board were typically members of the medical board, but as Farley explained, the historical precedent for the MCA board was that the business of organizing and fund raising was better suited to women. The board meetings were held monthly with strong participation and attendance by all the board members. Much of the money the MCA board reported in their monthly meetings came from individual donations, group donations, and foundational support. In some of the meetings, board members were planning to ask friends for financial donations.

In an effort to make her birth center plans more public, Lubic approached the National Organization of Women for support in the birth center idea since NOW was also a supportive presence in the women’s health movement. Despite directly asking the National Organization for Women (NOW) to help support the MCA’s freestanding birth center, NOW refused. Lubic’s friend and MCA associate explained the disconnection between MCA and NOW as being ideological. To her, NOW distanced themselves from

243 Interview with Phyllis Farley on February 3, 2011 by Linda Maldonado.
244 Ibid. Farley’s family was friends with Joe Kennedy of the Kennedy line.
245 Board Meeting Minutes, J Box 13, Folder 10, MCA.]
Lubic and the MCA because “the issues of abortion and birth could not be successfully fought for together. They needed to be separated.” However, Lubic held a different stance on the subject of NOW’s lack of support for MCA. When asked about this topic, Lubic responded that most feminists in the 1970s and 1980s involved with NOW did not want to be involved with the “pesky result of unprotected sex.” Lubic was also limited in her dealings with NOW due to the MCA’s stance on abortion. Lubic’s associate shared that Lubic was not permitted by MCA to discuss abortion as part of her position within MCA.

As part of the planning phase of the birth center, Lubic and the MCA board organized a meeting to discuss the possibility of conducting a pilot study of births in the U.S. Fifty experts representing medical, health, and scientific disciplines and organizations concerned with maternity and infant care met in New York at the invitation of MCA. The meeting was chaired by Dr. Bernard Pisani, Director of Obstetrics and Gynecology at St. Vincent’s Hospital and Medical Center, New York, and Chairman of the Board of Maternity Center. The meeting held a two-fold purpose which was to (1) explore the design, methodology and results of three national birth surveys conducted in Great Britain and (2) consider the initiation of a similar project in the United States—specifically, as a necessary first step, a pilot study to determine the feasibility of a national survey.

246 Farley interview.
247 Lubic interview.
248 Farley interview.
249 Birth Survey, Box 12, Folder 11, MCA.
Early in 1970, in correspondence with British colleagues and talks with U.S. health professionals, Lubic began investigating the possibility of conducting a birth survey in this country. She believed that a survey could serve at least three vital purposes: to gather baseline information, to examine the “state of the art” in maternity care, and to establish a new priority for maternity care within the health-care delivery system.\textsuperscript{250} At Lubic’s invitation, Drs. Josephine Barnes and Neville Butler led the meeting and offered a detailed presentation of three British birth surveys undertaken in 1946, 1958, and 1970 by the National Birthday Trust. The British birth surveys revealed the strengths and weaknesses of maternity services at a given point of time; led to an improvement in service quality and availability and in the utilization of services by patients; and contributed to a decline in perinatal mortality rates through a greater emphasis on early biochemical testing and intensive care. While Lubic wanted similar studies done in the United States, she soon faced opposition from physicians.

In the end, and after much debate, the idea of a U.S. survey on birth was voted down by the physicians. Indeed, the majority of the physicians on MCA’s medical board were afraid of the public seeing the high U.S. rates of infant mortality and the consumer backlash that would invite. One MCA physician made it a point to stand up and walk out of the meetings with the British physicians. Lubic shared, “This potentially informative and important study was never done in the U.S. despite meetings with the Institute of Medicine and the National Academy of Sciences.”\textsuperscript{251}

\textsuperscript{250} Ibid.
\textsuperscript{251} Phone interview with Ruth Lubic on February 11, 2011 by Linda Maldonado.
Lubic had hoped to see the U.S. birth study underscore the need for nurse-midwifery services nationally. Despite this disappointment, she was determined to use the MCA as an example of how trained nurse-midwives could be effective providers of maternal and infant care. Aware of the surging interest in the natural birth movement at the time, Lubic felt the moment was ripe for nurse-midwives to innovate. It was during this time that Lubic began rethinking her dissertation topic and her professional goals. The seeds of her dissertation topic and professional trajectory were hinged to the national push towards alternatives to hospital birth.252

Unhappy with the traditional system of medical care, some couples were opting for “do it yourself” homebirth. The idea of creating a center for childbearing grew out of Lubic’s determination to offer them a better alternative than either extreme: delivering at home or in a hospital. Planned as a demonstration project, the MCA’s Childbearing Center was designed to “test whether safe, satisfying, and economical out-of-hospital care could meet the needs of families who otherwise might employ such home delivery.”253 The Center was built around the philosophy that pregnancy is not an illness and that for the majority of women, childbirth is a “normal physiologic experience and not a pathologic event or surgical experience.”254

Lubic also wanted a fundamental change to occur in how couples were treated during prenatal care, birth, and the postpartum period. For Lubic, using midwives for

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252 Lubic held onto her anthropological beliefs concerning maternity care despite that topic not being the focus of her dissertation work. In a 1972 article entitled, “What the Lay Person Expects of Maternity Care: Are We Meeting These Expectations?” Lubic challenges the reader with the questions: who are the laity and do all groups define maternity care the same way? Lubic argues that providers of maternity care are in fact not providing the care that expectant mothers and their partners desire. She cites some feedback from MCA patients. Cite full article. Articles are in quotations, books in italics.

253 Lubic interview, February 11, 2011.

254 Current Biography Yearbook, 328-332.
prenatal care and birth was the nation’s answer to providing high quality, inexpensive (when compared to hospital birth), and highly individualized care to low-risk expectant women and their families.

Lubic’s vision and ability to endure were tested, however, by the fierce contestation she and her ideas faced by both formal and informal groups of official, professional, administrative, and bureaucratic assemblages.\textsuperscript{255} In one account, Lubic and Farley attended a November 11, 1976, American Public Health Association convention. Farley felt she needed to accompany Lubic because “Ruth appears to be the focus of attack” and Farley felt her presence would emphasize the fact that the Board is 100% behind the controversial Childbearing Center.\textsuperscript{256} The extent to which Lubic struggled to introduce changes into the healthcare system became manifested in her dissertation entitled “Barriers and Conflict in Maternity Care Innovation,” which she wrote after she became Director of MCA.\textsuperscript{257}

**The Upper East Side Childbearing Center and its Detractors**

The Childbearing Center (CbC) opened in 1975 amidst much controversy within the medical community. With the expectation that the role of midwives would thus be substantially greater than that of the obstetricians or pediatricians on staff, Lubic hired certified nurse midwives and physicians in a ratio of about three to one. The CbC was set up in a townhouse on the Upper East Side of the New York City borough of Manhattan. It was designed to offer comprehensive care in a home like atmosphere to healthy families anticipating a normal birth experience. As Lubic wrote, “It is a maxi-home and

\textsuperscript{255} Ruth Watson Lubic, “Barriers and Conflict in Maternity Care Innovation” (Ph.D. dissertation, Teachers College, Columbia University, 1979), 21.
\textsuperscript{256} Farley interview.
\textsuperscript{257} Board Meeting Minutes, Box 13 Folder 11, MCA.
not a mini hospital. Actually our starting point was the home with all of the emotional support, comfort, and security that it offers.\textsuperscript{258}

To foster emotional support, the center welcomed the presence, during labor and delivery, of the husband, parents, or friends of the pregnant woman or anyone else she chose to be with her. If she had other children, they too could keep her company and even observe the birth. In 1979, in another of its pioneering steps, the center began to offer classes to prepare children for the birth of siblings as part of its prenatal education program. If the parents are comfortable with the presence of older children and the children have been properly instructed, “it’s a harmless and wonderful experience,” Lubic said. “They bond to their siblings that way.”\textsuperscript{259}

The comforts offered by the CbC included a cozy family room and outdoor garden for women in labor and their companions as well as a kitchen where people could prepare a celebratory meal after the birth. Like those at other centers, its birthing rooms bore little resemblance to the harshly lit operating rooms where millions of American babies came into the world, with their mothers strapped to tables designed for surgical procedures. At the CbC, mothers delivered their babies while propped comfortably in a bed or in any other position they desired. Unlike their counterparts in the hospital, they did not have to undergo continuous electronic fetal monitoring and they rarely received

\textsuperscript{258} Current Biography Yearbook, 330.
\textsuperscript{259} Mary Daniels, a child psychologist by training, pioneered research on siblings at birth. Her research found its way to major national attention and guest appearances on The Phil Donahue Show in the 1970s. Because of Daniels’ research, women could have their families take on a more active role in the birth process within both birth centers and hospitals alike. Daniels was also part of the teen peer-counseling program in Philadelphia’s Booth Maternity Center (BMC). Booth Maternity Center was a level-1 hospital that provided care for women with low health-care risks, on City Line Avenue. Opened in 1970 as the Booth Maternity Center, the facility later changed its name to the John B. Franklin Maternity Center in honor Dr. John Franklin, a local physician who was committed to providing quality care to women and their families. The Franklin Maternity Center closed in 1987 because of a combination of inadequate reimbursement rates, a lack of outside funding support and a decline in patients using the facility.
anesthetics. Mothers also typically left the center within 12 hours of giving birth as
compared to the 24-hour stay in hospitals. Birthing center clients returned to their homes
armed with information about normal postnatal recovery and infant care, and were
assured thorough follow-up care. A public health nurse visited the family the next day
and again, if necessary, and the mother returned to the center for two postnatal
examinations. The total bill for service was substantially lower than the combined
charges of an obstetrician and hospital.

To help parents-to-be prepare for the responsibilities of childcare, in 1978 the
MCA added classes in “self-help education” to its program. In such classes the
prospective mother was taught among other things to record her weight, and test her urine
regularly, and the father or other support person learned skills such as blood-pressure
estimation and abdominal palpation. If, after checking the woman’s records, the family’s
nurse-midwife detected any deviations from the norm, she would alert a staff physician.
Clients received additional instruction in nutrition and physiological and other
phenomena associated with pregnancy and birth, and they learned relaxation techniques
to control tension and pain during labor and delivery. The center also offered
gynecological care as well as counseling in nutrition, reproduction, and sexually
transmitted diseases.

_Detractors_

Although couched in terms of concern for the safety of mothers and babies and
the quality of care they would receive, the disapproval voiced by obstetricians and
pediatricians was motivated primarily, Lubic eventually surmised, by fears of invasions
into their professional territory and loss of power and income. The types of attacks Lubic endured varied from the ideological to the highly personal. Outlined in her dissertation, Lubic gave detailed descriptions of actions attributed to the CbC’s detractors, ranging from multiple physician resignations from the MCA’s Medical Advisory Board to discrediting the CbC with insurers, foundations, nursing students, as well as CbC birth families.

The attacks on the financial realm of the CbC varied from discrediting the CbC with major foundation donors, attempts to halt Blue Cross reimbursement as well as disruption to the Medicaid process. Lubic shared that some foundations interested in the demonstration project were advised by unnamed individuals and groups against funding and withdrew their financial support. Despite some small grants given towards the self-help education program, the underwriting of startup deficits and evaluation funds were not secured. Blue Cross reimbursement did come through despite pressure from a large physician group that rallied with strong letters stating the CbC was “unsafe and that services should not be reimbursed.” No evidence was presented. The medical profession’s authority was the only rationale for the statements. The board of Blue Cross voted to reimburse on an experimental basis.

The battle to secure and maintain financial funding through the Medicaid reimbursement process proved to be the most draining to Lubic and the CbC supporters both financially and energetically. This battle, waged between the New York City Department of Health and MCA lasted from November 1975 to March 1, 1978. A letter

\[^{260}\text{Lubic, “Barriers and Conflict.”}\]
\[^{261}\text{Ibid, 125.}\]
dated September 2, 1977, from the New York State Commissioner describes the actions he took to “make the issuance of the Maternity Center Association’s Medicaid provider number one of my first actions in my new role. My resolve in this regard has been further supported by the publication of a very positive MCA evaluation compiled by Blue Cross/Blue Shield.” Six months later and approximately 2.5 years after the initial refusal, the vendor number was received by MCA.262

Rumor and Gossip

Lubic experienced a backlash of lies and personal attacks waged against both the center and her. Rumors circulated that the first CbC birth was a stillbirth and that the fetus was buried in the backyard of the CbC building. In addition, repeated rumors emanating from a physician from a nearby hospital told a tale of a maternal mortality at the center. Lubic responded to both rumors with a letter to the chief of staff at the hospital where the certain physician was employed. According to Lubic, the rumors faded and her letter was never acknowledged.263

A letter to Lubic from Dr. E.J. Quilligan confronted her with a “rumor” concerning his position on the use of fetal monitoring. In his letter, he stated, “I’ve heard that you are stating that I did not believe in monitoring. This is far from the truth.”264 Lubic responded to his letter with one of her own in which she clarified what she had gone on record saying in regards to fetal monitoring and Dr. Quilligan. “I have repeated the statement that you made at the Academy as I heard it, that there has been no definitive

263 Lubic still mentions the false rumors of the stillbirth, its burial in the backyard of the CbC building and the maternal mortality when talking about her detractors over thirty years later.
264 Dr. E.J. Quilligan M.D., to Lubic, September 30, 1975. He was Professor and Chairman of the University of Southern California School of Medicine, Department of Obstetrics and Gynecology. Letter from Dr. Quilligan, MCA, Box 148 Folder 10, Columbia University, New York.
and well-controlled study that has scientifically proven the value of fetal monitoring.”

This written conversation between Quilligan and Lubic is representative of the firestorm of debate that excessive use of fetal monitoring on all categories of pregnant women invoked, especially in the 1970s women’s health movement.

Another piece of gossip that surfaced during the first year of the CbC’s operation had to do with Lubic’s personal life. In a conversation with a physician who was providing physician coverage and back-up to the CbC, Lubic learned that other physicians were voicing disapproval of his work with the center. In a meeting, this particular physician was greeted by a physician peer who loudly proclaimed, “Well here comes the man who is sleeping with Ruth Lubic!” When Lubic asked him how he responded, the CbC physician stated, “Oh, I just said, ‘Yeah, Dr. so and so, and she’s a lot better than your wife!’” Indeed, gender presented its unique set of challenges where innovation was concerned, especially if that innovation competed with a specialty dominated by male professionals.

**The Federal Trade Commission Weighs In**

In a 1981 study by the Federal Trade Commission, the New York City obstetrical marketplace was examined. The report found that New York City shared many characteristics of the national obstetrics market of the 1970s. For example, birth rates had declined considerably as hospital costs continued to rise. The trend in health planning was to consolidate underutilized obstetrics service, which meant closure entirely for

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265 Ibid.
266 Lubic, “Barriers and Conflict,” 129.
smaller units. The study also asserted that projections of the birth rate made in the preceding decade had seriously underestimated the birth rate decline with the result that there was a surplus of obstetric professionals in certain markets.

Certain other characteristics of the obstetric market were significant. First, New York City lost many middle class residents in the 1960s due to their move to suburbia; and many young doctors followed them. The result was that members of the medical establishment in New York City’s prestigious medical schools were older and more conservative than their counterparts in comparable institutions elsewhere in the country. The consolidation of hospitals, particularly dramatic in the city, left more than twenty-five hospitals closed with more to be eliminated. Closure left staff doctors looking for positions in other hospitals as well as limiting available training opportunities for residents and nurse-midwives. This created a heightened sense of competition for clients that MCA was attracting.

Such developments had serious implications for nurse-midwives generally and for the CbC specifically. According to one physician associated with a major New York City hospital and teaching center, the obstetric scene in the 1970s made obstetricians and nurse-midwives competitors for the low-risk births. This physician, a specialist in high-risk births and serious complications, envisioned a complimentary relationship between low-risk pregnancies and births managed primarily by certified nurse-midwives with obstetric consultation as needed, leaving obstetricians and neonatologists (and hospital beds) available for the management of high-risk pregnancies, complicated deliveries, and newborns in need of intensive pediatric care. Because of the large number of skilled professionals competing for a limited number of low-risk mothers, the ideal utilization of
obstetric resources had been delayed because many obstetricians were unwilling to relinquish the low risk-mother, the obstetrician’s “bread and butter.”268

Notwithstanding intense criticism from many doctors, within a short time facilities based on the model of the CbC began opening elsewhere. By the end of the 1970s, according to a report prepared for the Federal Trade Commission, the “service provided by the center had a profound and almost all agree, a positive impact on New York City Hospitals specifically, and trends in obstetric care generally.”269 “At least partly as a result of the Childbearing Center,” the report continued, “many major New York hospitals are working to ‘humanize’ the delivery of obstetric care and to accommodate a perceived demand for family centered maternity care,” by developing expanded roles for nurse-midwives and fathers. They also set up birthing rooms “in an effort to appeal to the low-risk mother,” reviewing the use of monitoring devices and other equipment in low-risk cases, encouraging breast feeding and rooming-in, and shortening the length of the hospital stay for most mothers.270 The report concluded that the Childbearing Center had “demonstrated that safe, efficient care could be provided to low-risk mothers in a context utilizing teams of physician and non-physician professionals.”271

269 Ibid, 41.
270 See Current Biography Yearbook, 328-332. Elizabeth Mitchell Armstrong and Eugene Declerq detail how hospital maternity units responded to the consumer push by creating birthing suites that cleverly concealed medical equipment and other new technologies such as the fetal monitor behind quilts, and other accoutrements meant to invoke the comforts of home. In the 1980s and 1990s, a large percentage of women and their partners embraced these amenities even as obstetrics embraced more technologies that pushed maternity care back in the direction of medicalization. See Armstrong, Elizabeth Mitchell and Declerq, Eugene. “ Is it Time to Push Yet? The Challenges to Advocacy in U.S. Childbirth,” in Patients as Policy Actors, eds. Beatrix Hoffman, et al., (New Brunswick: Rutgers University Press, 2011).
271 Lewin, Competition Among Health Practitioners. 42.
In 1988, Lubic wrote for *Nursing Outlook* about her experiences with medical opposition and warned nurses to be on guard for overt and covert professional conflict as well as to be mindful of the true reasons behind opposition. Lubic shared guiding principles, such as careful selection of colleagues and focusing on specific patient needs, that reflected much of her own professional experiences and tensions she endured while bringing her innovations to fruition. She also emphasized maintaining a sense of humor, and importantly, being proud of being a nurse. The CbC was representative of Lubic’s political desire to bring increased autonomy to childbearing families. In this way, Lubic positioned her ideas as a challenge to medicine’s hierarchical relationships. The CbC brought care beyond the geographic and political confines of the hospital space and its physician-nurse-patient relationships. She argued the CbC was an innovative response to the frustrations experienced by many women with hospital systems’ depersonalized and routinized care centered on the medical model. Lubic’s innovation brought not only a solution but an alternative care provider to the scene: the nurse-midwife. The care provided by midwives in the CbC was seen as empowering to families and comparably less expensive than a hospital birth.

Another important component of Lubic’s innovation was her call to professionals to critically examine the various kinds of women’s social support before, during, and after birth. She pondered over the important and still relevant question of just who are

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272 Lubic, “Insights from Life in the Trenches.”
273 The Upper East Side Center charged $550.00 for a complete package of prenatal and postnatal care, delivery in a homelike environment, and educational services. This compared to the $2000.00-$3000.00 charge for a typical hospital inpatient delivery. See Fairman, “Go to Ruth’s House.”
274 Historically, birth was the domain of women with communities of women providing social support. Lubic wrote a provocative article challenging readers to conceptualize exactly who the recipients of maternity care should be. In 1980, the New England Journal of Medicine reported that the findings of a
these women and families for whom providers deliver care? What are their national origins, gender, ethnicity, occupation, race, and age? How does culture affect their expectations? The answers heavily contribute to the type of care the woman and her support system will receive both from medical/hospital and midwifery/birth center models alike. She drove home the argument of the importance of contextualized social support and medical care for the diverse types of childbearing women and their families. The difference in outcomes of these two different paradigms of care is especially visible when the attention is placed upon minority and low-income women and their communities. As minority activist voices within the women’s health movement declared, there are wide ravines of difference in terms of race and class when it comes to these various women’s health needs, concerns, and expectations source. These differences are embedded within the sociopolitical contexts from which these women emerge. Lubic argues that part of the foundation, in terms of care provided to women of various race and class, must include measures to honor human dignity as well as assist in fostering a sense of personal worth. Lubic contends that nurses and physicians must model as well as set the standard within their respective organizations, for how minority and low-income

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research project supported perinatal benefits of constant human support during labor. Lubic’s philosophy encouraged support during all phases of pregnancy and labor. See Ruth Watson Lubic, “What the Lay Person Expects of Maternity Care: Are We Meeting These Expectations?” JOGNN 1, no. 1 (1972): 25-31. See also Roberto Sosa et al, “The Effect of a Supportive Companion on Perinatal Problems, Length of Labor, and Mother-Infant Interaction,” The New England Journal of Medicine, 303 no. 11 (1980): 597-600. The articles all agree that the presence of a supportive person to a woman in labor not only improves the maternal perceptions of labor and birth but also is positively correlated with positive birth outcomes.

275 Lubic, “What the Lay Person Expects of Maternity Care.

women and their communities are received and treated within those various systems of care.277

**Childbearing Center of Morris Heights**

Intent on demonstrating how a community-focused, empowerment-driven environment can positively affect change within marginalized communities, Lubic and the MCA embarked on another birth center project in the late 1980s. The location of this new project sharply contrasted with that of the Upper East Side. The Lower East Side provided a stage for a childbearing center in an economically depressed section of the city. This primarily low-income community represented a diverse population of Blacks, Puerto Ricans, and Asians, among others. The economic level varied but the median income was one of the lowest in New York City. Over 70% of residents had incomes below the 200 percent Federal poverty level; Medicaid insured 28.7 percent; and 33 percent were estimated to be medically indigent. In the late 1980s, this particular area had the second worst infant outcomes with the District of Columbia holding first place.

The Childbearing Center of Morris Heights in the South Bronx opened in 1988. By utilizing the same type of philosophy that underpinned the Upper East Side’s CbC, Lubic and her staff of midwives worked with the same goals of delivering innovative care within an environment that fostered ongoing education and social support delivered this time to a low-income minority community. As opposed to the context of white middle and upper class women, Lubic’s Childbearing Center of Morris Heights, fostered the opportunity for low-income women to “own” their care.278 Lubic established care for a

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277 Lubic, “What the Lay Person Expects of Maternity Care.”
278 In 1992, Lubic produced a video of her work at the Childbearing Center of Morris Heights called *Hope Reborn: Empowering Families in the South Bronx*. The video shows how Lubic and her staff work with the
community whose concerns revolved around the barriers to care and high rates of infant mortality. Unsatisfied with the gap between provider and minority patient, Lubic placed women of minority and low-income status in charge of recording their blood pressure, weight, and other prenatal measurements in their own medical charts.

Lubic’s work with this low-income community also fostered within her a new understanding of the term “high risk” associated with many of the low-income childbearing women she served. Through a collaborative team approach with the women and families in their context and communities, Lubic and her team of midwives made an important discovery. Once these women were actively engaged in their prenatal care, the families became engaged and birth outcomes began to slowly and steadily improve. The processes of assisting familial and community empowerment became an important part of understanding the puzzle of infant mortality within minority, low-income communities. Just as important, the CbC midwives and their unique approaches to gynecological and obstetrical became the cornerstone between communities and health.

**Conclusion**

Nurse-midwives in the 1970s and 1980s were able to offer women expanded choices and increased access to services. Similar to the experiences of nurse practitioners, collaboration with physicians was essential, yet at the same time problematic. Nurse-midwives relied on physician colleagues to support their childbirth services and gain hospital privileges and coverage during hospital transfers. But in some instances,
physicians threw up barriers to freestanding birth centers, citing the dangers of childbirth outside hospitals despite the lack of concrete evidence.279

Women’s health activists such as Lubic persisted into the 1980s, albeit with new challenges. Despite adequate physician coverage to the CbC, the declining birth rate, maternity ward closures in New York City, and middle-class flight from the city created a competitive market for birth providers. The MCA’s CbC was no exception. Large numbers of practicing obstetricians in New York City created an environment of competition and conflict.

In 1995, the CbC closed its doors as a result of, as Farley explained, “a combination of money and pressure from the medical community.”280 Farley also went on to explain that the center was not attracting the same numbers of expectant couples as before. In addition to changing demographics of New York City, Farley also believed that people were “buying into the fear” of delivering outside of hospital walls.281 Yet despite the closure of the CbC, Lubic was already working on another freestanding birth center in an area of the country with some of the highest infant mortality rates. I discuss this center in the Epilogue.

279 Fairman, “Go to Ruth’s House”.
280 Farley interview.
281 Ibid.
Chapter Five

Conclusion
This dissertation has explored the collaborative activities of women’s health activists in two organizations, the MCC and MCA, which were committed to addressing infant mortality rates in two different geographic areas of the U.S. Specifically, it focuses on the key roles of nurses, thereby highlighting the significance of grassroots social movements in nursing history. The MCC and the MCA were similar in many ways. Both represented women who worked individually and collectively to produce accessible care that was an alternative to mainstream medical care. In so doing, both embraced nurse-midwives and their high-touch, low-tech approach as a central component in caring for marginalized women. Both organizations viewed their work as a strong component of the women’s health movement going on at the time in the 1970s and 1980s. Yet when it came to the on-the-ground operations, there were some compelling differences.

One major difference between the two organizations is that the MCC organization did not provide a place for women to give birth; it did not operate a freestanding birth center. Rather, advocates worked for women to seek and receive consistent, quality
prenatal care while also ensuring they were covered with the social services they needed such as food stamps, Women Infant Children (WIC) assistance, and other social services. The MCC activists were, however, highly supportive and in favor of nurse-midwives providing care for low-risk women. They were of the strong belief that low-income, minority women were often over-treated with unnecessary medical interventions and technology that benefitted the training of new physicians but held little benefit and sometimes actually harmed the women receiving that care.

The activists also had evidence, much of which was generated from Sister Teresita’s study, that many of the low-income, minority women were erroneously being turned away from care and/or treated as high risk due to their gender, race, and class. As a result of the treatment many of these women endured, some simply stopped seeking prenatal care. MCC patient advocate Dorothy Jordan focused much of her advocacy on getting these women appointments in the hospital clinics for prenatal care, often times having to remind the clinic staff of the rights of these women to receive equitable care. Once in the hospital system, Jordan worked with the women themselves, ensuring they adhered to “the system” by keeping their prenatal appointments and caring for their bodies as their obstetric providers advised. Jordan shared that she taught these women to “understand the hospital and welfare system so that they could use the system to get what they needed.”282 Jordan’s statement underscored one of the foundational welfare rights strategies at the time, which was the importance of gaining a working understanding of the system in which poor women had to operate. Whether it was welfare systems or hospital systems, knowledge was power in the hands of poor women. Once they

282 Jordan interview.
understood the system and its mechanics of operation, they were able to learn strategies to successfully navigate the negative aspects of it while gaining self-empowerment in the process.

Another important difference between the MCC and the MCA was in their approach to women’s health activism. The MCC activists utilized a wide range of activism, some of which was considered highly controversial at the time especially when compared to the activism of the MCA.\textsuperscript{283} The MCC as an organization was born from the energies of its founders. The work of Sister Teresita Hinnegan, Edward Sparer, and Walter Lear is representative of the various personalities that find themselves in social movement mobilization as Ziad Munson describes in his research that studies how these groups are formed and collaborate despite individuals’ differences.\textsuperscript{284}

Sister Teresita engaged as a member of the MCC as the result of her religious and spiritual calling. Her impact on the MCC began with her desire to help vulnerable women and was actualized by her training as a Medical Missions Sister, a nurse-midwife, and a social worker with a background in health policy. As the author of the study that looked at the health districts in Philadelphia suffering the highest rates of infant mortality, Sister Teresita became highly aware that these communities were in need of extensive social support. It was the actual printing and publication of her study that forced public officials to address the problem of tragically high rates of infant mortality in the city of Philadelphia.

\textsuperscript{283} Dan Berger, \textit{The Hidden 1970s: Histories of Radicalism} (New Brunswick: Rutgers University Press, 2010).

Sister Teresita operated out of a belief that the women who were suffering high rates of infant mortality were not to be blamed directly. As she was on the streets of Philadelphia listening to the stories of women trying to receive obstetrical care from local hospitals, she quickly learned of the institutionalized forms of racism occurring in the city. In her words, Sister Teresita and the other activists took those stories and “became a voice for the women.”²⁸⁵ Her role, as she saw it, was to take their stories, become their voice, and then bring those stories to those who made decisions at the city level. Those entities were the state and local health departments. She worked in tandem with the other founding members.

Sparer utilized his background as a welfare rights lawyer to construct effective communication to hospital officials and help serve as a guide to the activists advising them in their activities as they relentlessly maintained a campaign on several levels to bring Philadelphia’s infant mortality crisis into the direct vision of those in city government. Sparer brought with him a trajectory as “one of the few poverty lawyers who understood that a legal campaign was an organizing tool for a social movement, not the other way around.”²⁸⁶ Sparer and fellow MCC activists dedicated much of their energies into bringing their identified social issues into the public realm. This was accomplished through public hearings and meetings advertised by flyers and word of mouth. Sparer remained dedicated to MCC and the national War on Poverty until he suffered a heart attack and died at the age of 55.

²⁸⁵ Sister Teresita Hinnegan interview, November 19, 2007.
Lear served as the radical medical voice in the group’s initial phases. His background of work with the Medical Committee for Human Rights (MCHR), his health leftist leanings, and his long legacy of anti-war and civil rights protest activities molded him into a strong and at times contentious voice for the group. Lear made enemies with his leftist political leanings, the openness of his homosexuality, and his direct protest style, an example of which occurred when he attempted a lawsuit against the city of Philadelphia for ignoring the continued high rates of infant mortality in the city.

Lear also mentored Joanne Fisher who came to work with him initially as a student from Bryn Mawr School of Social Work. Lear played a highly influential role in Fisher’s professional trajectory as he taught her protest strategies and mentored her in leadership positions such as the one she took in initiating the Women’s Health Concerns Committee while she was still a student of social work. Fisher’s work currently as the Director of the MCC was built upon her radical start and mentoring by Sister Teresita, Ed Sparer, and especially Walter Lear with whom she maintained a close friendship until his death in May 2010.

Other important differences between the two organizations surround the topic of abortion and other issues. As part of her work agreement with MCA, Lubic was not permitted to discuss abortion access during her tenure there.\footnote{Lubic interview, June 24, 2009.} Sister Teresita did not involve herself with the abortion campaigns at MCC, but most important, she did not let the differences in ideologies stop her from her calling of helping vulnerable women. In addition, Sister Teresita did not remove herself from working with Lear despite his openness over his homosexuality. In fact, Sister Teresita spoke of how she appreciated
Lear for his work and his devotion to social justice for vulnerable women and their communities. His sexual lifestyle, while at odds with her religious beliefs, did not deter her from serving her purpose in MCC.288 This is one of many examples with the MCC where activists drew together over the goals of the organizations despite their profoundly different lifestyles and other personal beliefs. All of these responses provide insight into some of the tensions this organization endured as a part of the messy multiplicity of women’s voices during the women’s health movement.

As Munson describes in his work, despite nearly universal consensus on an ultimate goal, activists often have profoundly different ideas about the means to achieve that goal.289 The MCC activists are an example of what Munson describes as the patterned variation within a social movement that shapes the development of the movement as a whole.290 By contrast, Lubic’s freestanding childbirth centers were not as controversial as the MCC’s advocating for prostitutes and anti-war protesting. Lubic’s style of activism witnessed her disrupting the medical status-quo with her nurse-midwife led freestanding birth centers during a time when physicians were facing intense public scrutiny and competition. The negative reactions Lubic endured were often directed at her and her centers. Lubic’s deliberate decision to have birth centers in low-income areas achieved the result of providing low cost health care to low-income marginalized women while at the same time politicizing the communities’ positive responses to the centers, as well as ultimately promoting the profession of nurse-midwives to both the public and law-makers.

289 Munson, The Making of Pro-Life Activists.
290 Ibid.
Lubic and her supporters offer a different example of activist movement structure and operations. Lubic and her MCA board of directors were representative of women of means collaborating for philanthropic reasons as well as the politicization of the birth center and nurse-midwife movement within the larger women’s health movement. Lubic’s first freestanding birth center was nested in a private home in affluent East Manhattan. Her initial CbC was largely in response to the call from middle-class women who wanted more dynamic participation in their own experiences in health care and childbirth in particular and could not find ways to operationalize this. Lubic and her MCA board envisioned the CbC as a way to reduce the unsupervised in-home births occurring in New York City at the time while bringing these women into an environment that provided a home-like birthing experience without the technology driven, medicalization model of the hospital. The success and the message of Lubic’s center spread and was viewed as a win for the national women’s health movement as well as the expanding role of nurse-midwives.

Lubic did rely on the support of her middle-class following as well as the financial support and work of the MCA influential board members. Indeed, funds were needed to provide for the clinic. Unlike the MCC, Lubic did not initially reach into the communities of low-income women until she brought her next freestanding birth center into the Bronx in 1988. The women served there were very different from Lubic’s prior clientele. These women were poor, typically Black and Hispanic. But they also shared with women in the earlier center the aim to regain control over their bodies during and after birth. The midwives in the Bronx center allowed the clientele to keep their own medical records and document their own blood pressures and weights. This effort was a
deliberate attempt at assisting women in their self-empowerment. When Lubic won her MacArthur Foundation Fellowship in 1993, she began her plans for the next birth center. In 1995, Lubic’s first CbC shut its doors. With her MacArthur Foundation Fellowship monies in hand, she left her position as General Director of MCA in order to start the planning phase of her next freestanding birth center.

Lubic’s Family Health and Birth Center in the District of Columbia opened in 2000 and exists even today with continued positive response from the community and medical support from sufficient medical staff and hospital back up. The nurse-midwives at the center are dedicated to serving women from all communities while providing continuity of service as its resources cover the entire pre and post delivery period and beyond. They provide educational programs on child-care, job skills for mothers, and nutrition counseling.  

Lubic also works tirelessly to bring her center’s success and the pivotal role of nurse-midwives to the attention of lawmakers not too far away in the nation’s capital. She often makes trips from her center to Capitol Hill where she is either meeting lawmaker friends for lunch or providing testimony on the needs and success of the Family Health and Birth Center. Lubic often goes armed with data she compiled from her center that illustrates some of the disparities and the success of the center’s efforts to address them. For example, the proportion of preterm births for the Black population in the District of Columbia was 14.2 percent compared to 9 percent at the Family Health and Birth Center. As Fairman argues, cost savings and social justice alone are not reason enough

292 Ibid.
for service support from local and national government sources. Yet in this cost-conscious health environment, cost savings have become the standard of therapeutic success. Nurse-midwives positioned in a context of vibrant community support are a strong part of the answer in today’s health market. By 2007, it was clear that Lubic and her colleagues’ work was changing lives. At a legislative hearing, medical doctors were recommending that "Ruth's house" was a place to get help in preventing tragic infant deaths.

Both the MCC and the MCA achieved positive results through different styles of operationalizing their activism. Whether or not members of either organization identified as feminists, their work can be unpacked and understood as having strong feminist underpinnings. For example, the exposure and dismantling of persistent oppression of women and women’s voices in mainstream medical institutions and political systems was one cornerstone of both MCC and MCA. Feminists in the national women’s health movement challenged medical models of gynecology and birth through organizing, consciousness raising, education, as well as confrontational strategies when necessary. Both the MCC and the MCA employed parallel strategies with their detractors. When asked about contending with opposition, MCC’s Sister Teresita replied, “you cannot alienate yourself from people who disagree with you. Listen to them and then you get a good idea of how to organize yourself. Knowing how to challenge that opposition is really important.”

293 Ibid.
Interestingly, Sister Teresita, in a parallel fashion to feminists who voiced their displeasure towards the profession of nursing, also voiced disappointment in the more contemporary nursing profession and its “complacency and passivity.” 296 Sister Teresita blamed a fear that many nurses have of losing their employment if they speak out. She also voiced her opinion that nurses, as a whole, are not involved enough at the political level where healthcare decisions are made. Sister emphasized the importance of networking and interdisciplinary collaboration to ensure the goals of the organization are met. Both MCC and MCA depended upon successful collaborations in their respective ventures.

Sister Teresita’s observation of nursing’s absence from social justice activism is important. It brings up the fact that during this period and even in contemporary times, not all nurses and nurse-midwives work toward health equity. Indeed, nursing is not a homogeneous profession. At the same time, even at MCC and MCA, professional objectives such as making sure appointments were kept or that medications were taken sometimes took priority over patient advocacy, since some patients’ priorities may have differed.

Yet, despite differences and the vocal opposition they had with other organizations, both MCC and MCA witnessed marked success and forged enduring paths for their unique organizations. Sister Teresita and Lubic, in collaboration with many other individuals and groups, addressed their city’s charge of enduringly high infant mortality rates. It was this collaboration that made their work possible. And they did not limit their vision to infant mortality. Indeed, infant mortality was a problem that many powerful

296 Ibid.

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leaders supported. The MCC and MCA moved beyond the issue by also focusing on women’s empowerment. And they examined problems by looking not only into them but also beyond them, into the sociopolitical context. Both organizations navigated through the issues with the conceptual notion that human existence and its context or environment are integrally related, forming a unity that cannot be separated. They viewed the issue through a nursing lens that views the experience of each individual as a complex totality that cannot be broken into segments. As Chinn argues, “nursing has remained committed to developing interactive processes emerging from traits such as caring and nurturing that have been devalued by patriarchal systems. Reverence for life, reverence for the environment, and respect for each individual’s (and/or community’s) uniqueness are common to all nursing theories. These tenets are also central to feminist theories.”

As my study argues, nurses and their collaborative relationships were pivotal to their communities’ repair and reform of health inequity. It is for this reason that nursing needs to have a voice and meaningful presence in the future of healthcare reform. Drawing from these organizations’ histories is important as health policy makers undergo healthcare reform that will necessitate the inclusion of nurses and nurse-midwives to meet the many health needs of the population, especially women and children.

Future research will involve interviews with clients of MCC and MCA, their relatives, and other community members. These perspectives will provide insight into their perspectives of access to care, being treated by nurse-midwives instead of

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297 Peggy L. Chinn, “Feminism and Nursing: Can Nursing Afford to Remain Aloof From the Women’s Movement?” Nursing Outlook 33, no. 2 (1985), 76.
obstetricians, and what their own priorities were. They also will provide additional viewpoints about women’s roles in this important movement.

Epilogue

The MCA’s freestanding birth center became a model for others across the U.S. By 1983, freestanding birth center care was being provided at 103 out-of-hospital facilities in thirty states. In 1996, according to the National Association of Childbearing Centers, now the American Association of Birth Centers (AABC), there were 145 birth centers in the United States and 100 more in various stages of development. According to the AABC, in 2011, it is estimated there are 230 operating centers. The MCA and MCC remain key components of this system.

In 1993, Lubic became the recipient of a MacArthur Foundation Fellowship. Utilizing these award monies and other sources such as funding from HUD, Lubic
subsidized her next project: the Family Health and Birth Center (FHBC) located in Washington, D.C. Lubic’s center works with the collaboration of two other nonprofit service providers: the Healthy Babies Project (HBP) and Nation’s Capital Child and Family Development.

Following her own principles of working with communities and community leaders, Lubic engaged the interest of John Hechinger, hardware magnate and owner of an abandoned Safeway supermarket. Hechinger, at first, was not interested in becoming a part of Lubic’s plan. Eventually, Hechinger donated the site to Lubic’s project.298

Similar to the Morris Heights CbC, the location of this endeavor was also in an impoverished area. Known as Ward 5 to DC planners and “Little Vietnam” to the local residents, the community had a reputation for high crime, poverty, and a grim statistic. The average life span of a man from Ward 5 was 56 years of age if he were lucky enough to survive the first year of life after birth.299 In the 1990s, Ward 5, an area composed of primarily African Americans, along with Ward 7 and 8, held the nation’s top spot for infant mortality and maternal disparities. (See Tables 4 and 5)

Before the physical structure was in place, Lubic believed she had to first gain trust from the community itself. As opposed to the Lower East Side CbC with its heterogeneous community comprised of several minority populations, Ward 5 was

298 John Hechinger played an important role in the development of Washington, D.C. in the mid 20th century. Hechinger was one of the few real estate developers who crossed racial lines and built real estate in Black communities. Lubic sought the assistance of Donna Shalala, Health and Human Services secretary for the Clinton administration to help win over Hechinger. In 1997, after three years of being hounded by Lubic and her supporters, Hechinger offered a deal: The center could lease the supermarket from Hechinger Enterprises for $1 a year, for up to 20 years. Ruth turned him down. Babies were dying, and Hechinger was a rich man, she said. Why couldn’t he just donate the property? A few months later, Hechinger relented; Lubic could have the building outright. Lubic was reportedly delighted, but asked Hechinger to pay for a new roof. He gave into that request as well. See Phuong Ly, “A Labor Without End,” The Washington Post, May 27, 2007.

299 Lubic interview, June 24, 2009.
comprised of predominantly poor Blacks. Lubic and an African American employee from
the Healthy Babies Project attended neighborhood community meetings. Once having
gained entrance into the community, Lubic would show a video, *Hope Reborn: Empowering Families in the South Bronx*. Lubic would also tell the participants in the meetings that she realized she was “the wrong color” and that she was from the “wrong place” (New York). After the screening of *Hope Reborn*, in Lubic’s words, “my motives were off the table and race was off the table.”

Race, however, was never really “off the table.” Lubic was challenged by a D.C. nurse-midwife as to her “favoritism” towards the African American population and not concentrating her time and energies on Hispanics. Lubic’s response was that her focus was on the most “grotesque” national outcomes first in that Blacks had the highest rates of infant mortality. Indeed, rumor and gossip continued to be an enduring part of the process and life of being a change agent.

In 1998, Veronica Hartsfeld was a member of the Carver Terrace neighborhood community, as well as President of the Carver Terrace Civic and Tenants Association. As an advocate for her community members, Hartsfeld was also considered a respected and motherly figure for many of the community's Black youth. In an oral history interview with me, Lubic revealed that she knew she needed to make friends with Hartsfeld in order

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300 Ibid.
301 Ibid.
302 Nancy Naples’ research on community workers involved in the 1970s War on Poverty, found that many women from low-income backgrounds choose to stay in their communities and try to improve them, even when they have acquired education and the means to move out. Naples has termed this empowering sense of responsibility for improving the lives of family and fellow community residents “activist mothering.” See Tamar Carroll, “Forging a Multiracial, Class-Based Women’s Movement in 1970s Brooklyn,” in *Feminist Coalitions: Historical Perspectives on Second Wave Feminism in the United States 2008*, ed. Stephanie Gilmore (Urbana: University of Illinois Press, 2008).
to gain the trust and acceptance of the community. Lubic, accompanied by a Black female employee of the Maternity Center Association, showed her ten-minute video of the Healthy Babies Project at community meetings organized by Hartsfeld. Largely as a result of the information shared and the approval of Hartsfeld, the community embraced Lubic's idea for a center.

Hartsfeld, an established member of the community, was intimately familiar with her community’s problems. Both Hartsfeld and Lubic relied on each other for the success of this program. Hartsfeld played an instrumental role toward her community eventually trusting Lubic and accepting the purpose of the health center. Indeed, the legacy of medical mistrust from Black communities undoubtedly played a significant role in the way Lubic approached the Carver Terrace community with the idea and philosophy of her birth center. Lubic recalled how she did not feel it was her choice to pick a color for the building when it was time to meet with painters. Lubic turned to the Carver Terrace community and asked them what color they wanted the building to be. With tears in her eyes, Lubic recalled the community women picked the color purple. When Lubic asked them why purple, they responded with, “because it is peaceful.”

Lubic and Hartsfeld became friends despite their race and class differences within a geographic area that still held them apart. Hartsfeld had spent most of her life in the drug-infested community of Carver Terrace. On the other hand, Lubic shared residences in New York City as well as Washington, D.C. They forged a bond because each had a vision of healthcare for women, and it was not what the general medical society was offering. As Hartsfeld was dying from breast cancer, Lubic visited her and shared with

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303 Lubic interview, June 24, 2009.
her that there was no graffiti or attempted break-ins to the center since its opening three years prior. Hartsfeld’s answer to Lubic was, "I told them, leave it alone; it's OUR Center." These words provide a glimpse into the intersectional nature and mutual ownership of a community center between women of various races and classes.

The bonds between the two women persisted for several years until Hartsfeld’s death. Lubic and Hartsfeld’s friendship is representative of the collaborative efforts of midwives’ work with a wide range of women’s health activists. Both women were leaders in their own sociopolitical contexts: one a well-known midwife and the other, a highly respected member of an inner city community. Their alliance as women creating positive change for other women became a powerful catalyst for community change.

Significantly, Lubic knew that if a midwife-led out-of-hospital birth center could make a difference in this location, the city of Washington, D.C., could stand to save millions of dollars in health care. While other U.S. cities also held high rates of infant mortality, choosing Washington, D.C. served an important part of the various political implications of Lubic’s work. The D.C. Center’s midwives’ positive birth outcomes were being displayed right under the eyes of those in the seat of government and in political power.

Despite her best efforts to work equitably around differences in race and class with those around her, Lubic recently shared that her personal motives still come under suspicion from both co-workers and the outside public. A rumor recently started at her D.C. Center that she is of the Jewish faith. As in the other cases of relentless rumors and gossip, of which Lubic and/or a birth center was the target, Lubic calmly and with a bit of

304 Ibid.
humor, gave the facts. She walked into the room where the rumor initiators were assembled and told them, “If you are going to hate me for my religion, at least get the religion correct! Would you like me to sing for you the entire The Old Rugged Cross? Because you know I was raised Presbyterian!”

The D.C. Center’s positive birth outcomes and cost-effective services have saved the health care system $1,153,051 annually. The Center’s demographics also changed when in 2007 a birth center in Bethesda, Maryland, closed. Having served mostly privately insured patients, the clinic served a primarily white population of patients. As a result of the closing, there were 30 some families that came to look at Lubic’s center. Some of those expectant mothers voiced concern that if they went into labor during the nighttime, they would have to enter the crime-ridden neighborhood where Lubic’s D.C. center resides. Despite their concerns, many women from outside the Carver Terrace neighborhood do choose to deliver at the center.

Through their work, Lubic and the nurse-midwives at the FHBC actualized cost savings and quality in a low-tech, high-touch environment that provided social support, careful monitoring during pregnancy and delivery, nutrition and health education, as well as community outreach. Lubic’s individual activism and her search for funding and consciousness raising challenges, as Fairman argues, the primacy of larger institutional movements and positions her work as essential to supporting broader social change. The FHBC is one more example of individual and community activism working together to improve access to health care.

305 Ibid.
306 Fairman, “Go to Ruth’s House.”
307 Ibid.
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