Introduction

The Constitution of the World Health Organization declared in 1948, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Yet, this idea was not predominant in the United States immediately after World War II. Social movement activists in the United States, including those involved in the civil rights, New Left, and feminist movements, gradually transformed the meaning of health care beyond the medical treatment of individual bodies. This book tells a part of that story. Activists involved in the civil rights, New Left, and feminist movements redefined health to encompass traditional notions of medicine—the curative properties of medicine and the medical technologies utilized by medical practitioners—as well as less conventional ideas about “healthy” social and political environments that promote bodies free of disease as well as whole humans who are able to work productively, raise healthy, educated children, and fashion communities free of violence and social inequalities. Civil rights activists like Dr. H. Jack Geiger, for example, argued that the cure for hunger was both plentiful and nutritious food and the eradication of poverty through community action. He recalled,

[I]n addition to the medical care we provided, we had food and other models of activism. We repaired housing. We dug protected wells and sanitary privies. We urged people to start vegetable gardens, and a thousand families raised their hands, and that gave us a better idea. With a grant from a foundation as a start-up, we rented 600 acres of good land, land that was sitting empty nearby in the Delta [Mississippi], and organized what we called the North Bolivar County Cooperative Farm, in which the members of those thousand families pooled their labor to grow vegetables instead of cotton, and worked for shares in the crops. We invented a new occupation: nutritional sharecropping.2
Geiger and other activists created the collective farm and associated medical clinic to address what they believed were the social and economic bases of both ill health and generational poverty.

Later in the 1960s and early 1970s, feminists generated a women's health movement that shifted the struggle to revolutionize health care to a focus on ending the sex discrimination and gender stereotypes perpetuated in mainstream medical contexts. Like civil rights and New Left movement activists, they transformed the meaning of health and health care, associating them with a revolutionized social landscape in which women had power to control their own life choices. Many feminists argued that women's second-class social status was powerfully reinforced by both legal and medical institutions (and the male legislators and physicians who populated those institutions) that narrowly restricted women's ability to make their own choices about reproductive health care. Thus, feminists made the campaign for legal abortion central to the Women's Liberation movement. They maintained that in order for women to shape their own life paths, including making the choice to enter into sexual relationships without necessarily marrying and starting a family, they would need reproductive autonomy, which required both easily accessible and affordable contraception and legal abortion. Yet, feminists quickly expanded their campaign beyond legal abortion, emphasizing that the medical context in which women acquired health care was also fundamental to women's overall health and social status. During the early years of the movement and as it evolved, women of color feminists pressed the movement to make eradication of socioeconomic barriers to health and reproductive autonomy more central to a feminist political agenda.

Historians of the women's health movement usually begin the story with the Women's Liberation movement of the late 1960s and 1970s.³ I have chosen to ground my telling of the history of how the women's health movement helped transform ideas about health and health care in the earlier civil rights and New Left movements, which laid the groundwork for feminist women's health activism. Ideas about revolutionizing health care in order to transform social hierarchy were very much a part of both civil rights and New Left activism, and many of the women who became involved in the feminist movement first worked with these prior movements. Of course, many histories of the Women's Liberation movement acknowledge the roots of feminism in the civil rights and New
Left movements, so in that sense my telling is not original. My original contribution is to trace how ideas of revolutionary health care that flourished in the 1960s continued to be developed by Women's Liberation feminists and women of color feminists through the 1990s.

Scholars of U.S. feminism have long been complicating the historical narrative in order to better represent the way race and class affected experiences of sex, gender, and reproduction and transformed political demands forged by feminist activists. This book fits into this burgeoning historiographical tradition, which includes my first book, *Women of Color and the Reproductive Rights Movement* (2003). Since the publication of that book, there has been an explosion of historiography that deepens our understanding of how race and class experiences shaped feminist organizing around health and reproduction and affected women's experiences of reproduction and sexuality.

A broader focus on regional diversity has also expanded our historical understanding of feminist movements of the late twentieth century. With chapters on the women's health movement in both Seattle and Atlanta, this book helps to develop our understanding of the movement beyond what had been a rather narrow focus on the movement in New York City, Boston, and other parts of the northeast of the United States. There is no doubt that women's health activists across the country communicated with each other. They shared texts and, as Michelle Murphy points out in her book, “local stratified histories . . . were joined by road trips on interstate highway systems, telephone networks, mimeographed or photocopied pamphlets, manifestos, and periodicals transmitted through mail.” As Murphy's description of these networks suggests, we need to better understand feminist activism outside of major urban centers in the United States, on the West Coast, and in the Northeast, and we need to know more about feminist activism in southern states. I also see a need for deeper understandings of the connections and interactions between United States feminists and feminists fighting for gender and sex equality outside of the United States. These parts of the story will need to await another book and future scholars. In this book I will demonstrate that attention to the relationship between socially embedded inequalities and campaigns for better health has deep roots in social movements in the United States, particularly in the movement for civil rights, the New Left social justice campaigns, and feminism.
Civil Rights and Human Rights

While voting and political rights took center stage in the public civil rights movement, much of what poor African Americans wanted and needed on a daily basis had more to do with basic survival—a prerequisite for political enfranchisement. Movement organizers responded to demands for basic needs made by everyday people living with Jim Crow. The Student Non-Violent Coordinating Committee (SNCC) sponsored community projects and freedom schools to attend to basic needs (like demands for food and clothing) among blacks and to build support for the movement. During Freedom Summer (also known as the Freedom Project), in 1964, the Council of Federated Organizations, a coalition of civil rights groups, appealed to medical professionals to support civil rights workers with medical assistance. The Medical Committee for Human Rights (MCHR), an interracial group of physicians, dentists, nurses, and medical students, responded to this call and sent more than one hundred volunteers to Mississippi for Freedom Summer. Some of these volunteers stayed in Mississippi after the voting rights drive ended in reaction to the dearth of medical care available to poor African Americans.9

Dr. Geiger was one of the physicians who stayed in Mississippi to address entrenched medical problems among African Americans (many of whom were not civil rights workers) linked to long-standing racial and class inequities. These inequities were sustained by legal Jim Crow segregation and political disfranchisement as well as interconnected systems of economic deprivation enforced by physical violence, which was sanctioned by a powerful white supremacist social and political hierarchy. Geiger recognized that the accrual of legal civil rights would not guarantee the provision of life necessities for African Americans. While important, legal rights alone would do little to dismantle white supremacy. Alondra Nelson, historian of the Black Panther Party and its work to fight medical discrimination, calls the “gap between civil rights and social benefits” a “citizenship contradiction.” She explains in her book that the Black Panther survival programs founded in the 1970s were an “effort to provide resources to poor blacks who formally held civil rights, but who by virtue of their degraded social status and social value lacked social and economic citizenship.”10 MCHR, Geiger, and other civil rights
activists who created the first Community Health Center demonstration projects in Boston and Mound Bayou, Mississippi, understood that legal rights were hollow guarantees without economic and social transformation that included the empowerment of the poor to help forge solutions to their own problems.

Geiger, MCHR activists, and many feminists, both international and those in the United States, and particularly many women of color feminists, have understood that health rests on the “social determinants of health—housing, and food, and income and education, and employment, and exposure to environmental danger—and their consequences.” Thus, while medicine and technical intervention to cure disease is important, it is also fundamental to transform social formations and hierarchies that disempower certain groups on the basis of race, class, sex, sexual orientation, and/or gender so that all humans have access to the means to live healthy lives. All of the activists I write about in this book recognized that social transformation also required the involvement of individuals and communities in their own health promotion. Geiger wrote of this fundamental lesson learned from his work creating Community Health Centers designed to address complex causes of sickness and health in poor communities. “[C]ommunities of the poor,” he explained, “all too often described only in terms of pathology, are in fact rich in potential and amply supplied with bright and creative people. . . . [and] health services which have sanction from the larger society and salience to the communities they serve, have the capacity to attack the root causes of ill health.” In other words, Geiger believed the solutions to public health problems often existed within communities themselves.

In 2012 Eli Adashi, Geiger, and Michael Fine wrote an article that appeared in the New England Journal of Medicine in which they argued that Community Health Centers will continue to play an important role in the successful implementation of the Affordable Care Act (ACA). The ACA will probably insure thirty-two million more Americans with primary care needs. Many of these people will need more than primary medical care, however. Fortunately, the legacy of the civil rights commitment to addressing problems of social inequality is still embedded in Community Health Center (CHC) delivery of health care. The authors note that “CHCs pride themselves equally on providing community-
accountable and culturally competent care aimed at reducing health disparities associated with poverty, race, language, and culture. Indeed, CHCs offer translation, interpretation, and transportation services as well as assistance to patients eligible to apply for Medicaid or the Children’s Health Insurance Program (CHIP).” Yet, there is concern that the underwriting of the CHCs by the federal government may also narrow health delivery to medical care (combating disease) with reduced emphasis on social transformation.

Women’s Liberation

As CHCs were established across the country to address social inequality as a primary cause of ill health in the 1960s and early ’70s, women, both patients and organizers, noticed that many practitioners at free clinics (both federally funded in the CHC network and independent clinics) still failed to treat women’s health problems seriously or to listen to women when they asked questions about their bodies. Private physicians and hospital staff could be even worse. Women’s health activist Barbara Ehrenreich explains that women were often told by doctors that their concerns were “trivial,” and those concerns were dismissed. In 1973, in the widely distributed Women’s Liberation pamphlet Complaints and Disorders, Ehrenreich and Deirdre English wrote that they understood “medical sexism as a social force helping to shape the options and social roles of all women.” One of the ways women’s “social roles” were shaped was through definitions of the female body as inherently sick if middle class or sickening to others if working class. In both cases women’s bodies were managed, although upper-class women were defined as weak and perpetually infirm whereas working-class and poor women’s bodies were represented as vectors of disease. In response to their personal experiences with medical sexism, women involved in a burgeoning Women’s Liberation movement began building clinics—literally with their own hands and tools—devoted to women only and began to define health care delivery for themselves in ways that challenged sexed and gendered hierarchical power relationships, which in turn impacted both medical delivery and health. As historian Judith Houck points out, “At issue . . . was the question of professional authority, not between professional groups, but between health care profession-
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These women began what is now termed the “feminist women’s health movement,” which continues to be a vibrant part of feminist activism to this day.

Illegal abortion stood as one of the primary challenges confronting early Women’s Liberation activists involved with the women’s health movement at the end of the 1960s and beginning of the 1970s. Women who acquired abortions in the “illegal era” reported a variety of experiences, from hospital abortions doled out by panels of physicians to illegal but relatively safe procedures performed by physicians and other practitioners to dangerous self-abortions and abortions that led to complications and even death. As abortion gradually became legal and more readily available in the states and, after Roe v. Wade in 1973, legal nationally, feminists felt they had achieved a large step towards sexual equality. Yet, they still wanted to ensure that abortions were accessible and provided in safe and caring environments, particularly since the Supreme Court decision directed that abortion needed to be provided by physicians. Many feminists did not trust physicians to provide abortions in a feminist setting. As Ehrenreich and English wrote in 1973 in the context of a feminist narration of the development of a medical profession that marginalized women’s traditional healing practices, “women’s dependence on doctors . . . may have increased since 1900. Doctors moved in on each sexual or reproductive right as soon as it was liberated: they now control abortion and almost all reliable means of contraception.”

Feminists also fought to relieve the stigma associated with abortion. Abortion has been the single most debated and controversial health care necessity demanded by feminists. It has also remained a stigmatized procedure—even among women who have abortions. Feminists involved in campaigns to legalize abortion and those active in the women’s health movement in the early years of abortion legality wanted women to understand that abortion was a legitimate choice and also that those who made the choice should not feel ashamed. In order to relieve the stigma, they discussed abortion in consciousness-raising groups and held speakouts where they publicly told stories of their abortions. Campaigners against legal abortion, referred to as the “Pro-Life movement,” fought to make abortion both illegal and shameful as they emphasized the importance of fetal “life” separate from the lives and bodies of women. Women who had abortions, they argued, were either victims
or careless, promiscuous, and responsible for killing their children. Recently the Pro-Life movement has developed a new strategy that blames women for damaging the health of the fetus through drug use or rejection of court-ordered medical interventions such as cesareans.20

**Women of Color and Human Rights**

While feminists involved in the women's health movement and abortion rights campaigns acknowledged that class and race framed health disparities, and often had an impact on who could access a safe abortion or who was subjected to population control measures like sterilization, their emphasis often rested on discriminations associated with sex, sexual identity, and gender. As Michelle Murphy astutely noted in her book, white women in the movement often focused on sharing knowledge about an “already ‘healthy’” body, whereas black feminists “repeatedly characterized the collective biopolitical conditions of black women using the words of the civil rights activist Fannie Lou Hamer . . . ‘sick and tired of being sick and tired.’”21 Women of color involved in early feminist organizing pointed out that race and class profoundly shaped which issues were prioritized in any political mobilization around health, reproduction, and the medicalized body. Issues of sterilization abuse, other medical abuses, poverty, and welfare rights were particularly relevant to women of color and often marginalized by white feminists who focused on abortion legality. Women of color feminists fought for legal abortion as well, and improved access to abortion that included state and federal funding, but, at the same time, they insisted that abortion and reproductive rights be understood as fundamentally linked to a campaign for intersecting social justice demands.22 For example, Beatrix Hoffman, historian of the history of health care rationing in the United States, writes that the National Welfare Rights Organization, an organization comprised of mostly black female welfare recipients, formed a Health Rights Committee in 1970 and demanded, “Just as all people have welfare rights, we believe they also have health rights.” They claimed that health care should be provided on the basis of need as a fundamental right rather than on the basis of income. They also demanded that physicians not refuse Medicaid patients or tolerate experimentation on the poor; they wanted hospitals to include community members on their
Many white feminists responded positively to criticisms made by women of color, although not without difficult conversations that often left women of color exhausted and frustrated. The feminist campaigns to protect legal abortion often kept abortion on the front burner of battles for reproductive rights and health care reform.

By the 1990s, women of color feminists in the United States, with historical links to the civil rights movement, New Left social justice campaigns, the welfare rights movement, and the Women’s Liberation movement, framed their struggle for reproductive justice for all women as a movement broadly associated with human rights. Loretta Ross, reproductive justice activist and historian of the movement, explained, “[W]omen of color activists demand ‘reproductive justice,’ which requires the protection of women’s human rights to achieve the physical, mental, spiritual, political, economic and social well-being of women and girls.” The demands of the reproductive justice movement are not demands for legal “rights” alone. Rather, demands hinge on associations between health promotion and the satisfaction of basic human needs. Ross, Sarah J. Brownlee, Dázon Dixon Diallo, and Luz Rodriguez, members of the SisterSong Collective, a women of color reproductive justice organization, clarified that “rights are born out of needs; rights are legal articulations of claims to meet human needs and protect human freedoms.” They further explained why a human rights framework is appropriate to help meet women of color’s particular political demands: “The United States lacks a sufficient legal framework that guarantees women of color safe and reliable access to health care; emphasis on individual civil and political rights neglects economic, social and cultural human rights.” They went on to point out that human rights ensure that legal rights are accessible: “The human rights framework challenges the United States to demand that economic, social and cultural human rights receive the same level of priority and applicability as that given to civil and political rights.”

A human rights discourse moves the conversation beyond the dichotomy of the “right to choose” abortion or carry a pregnancy to term versus the absence of that choice to an understanding that real choices require economic, cultural, and social environments that ensure a real range of options. If a woman has the right to choose an abortion but she cannot afford it and federal Medicaid will not pay for it, does she really have a choice? Her choice might be reduced to self-abortion, going with-
out other necessities to pay for an abortion, or carrying an unwanted pregnancy to term. What happened to her right to choose an abortion? Abortion is legal, but it is not accessible to many women. Women of color involved in the reproductive justice movement insist that government has an obligation to ensure an “environment in which policies, laws, and practices enable women to realize their reproductive rights.”27 A human rights frame insists on providing the “means” for meaningful choices—and real access to rights guaranteed by law.

While women of color activists have allied with the Pro-Choice movement, scholars of the reproductive justice movement point out that reproductive justice is not a “subset of the pro-choice movement.” Reproductive rights scholar Kimala Price asserts, “It is a movement in its own right; the difference is that intersectional politics are at the center of its political mission and vision. Intersectional politics informs its political agenda.”28 Rather than building a movement around demands for personal reproductive control, reproductive justice activists’ inclusive demands foster a coalitional politics across common interests. Maintaining abortion legality, ensuring abortion access, protecting and strengthening women’s access to various forms of birth control, educating and protecting women from reproductive abuses and population control, as well as fighting for an environment in which women can bear and raise healthy wanted children are at the center of the coalitional struggles of the reproductive justice movement. Other issues of importance are ensuring the reproductive rights of incarcerated women, ending gender and sexual violence broadly defined, and promoting sexuality education. Price also points out that reproductive justice organizations have organized with social justice movements not associated with reproductive politics or health care promotion; for example, in California, reproductive justice activists partnered with immigrant and civil rights organizations to defeat initiatives that would restrict access to voting.29

Chapter Outline

In the remainder of this book, the first chapter traces the emergence of the Neighborhood Health Center movement from the civil rights and New Left movements. Health care was fundamentally linked to the eradication of poverty and the social inequalities that sustained poverty.
Neighborhood Health Centers built by these campaigns for broad health promotion that advocated economic, social, and legal equalities paved the way for today’s Community Health Centers, which are likely to provide important preventive health services as the Affordable Care Act is implemented in coming years. The health care movement that came out of the civil rights movement, however, also linked preventive care to addressing the lack of power held by the poor to craft solutions to their own problems. They believed that community health care could be used to mobilize people to fight against economic and social inequalities that produced cyclical poverty and ill health linked to factors such as lack of access to healthy food, clean drinking water, or adequate housing. Although not the first Americans to insist that the roots of ill health were not linked to disease per se, but rather to deep social inequities associated with race and class, those who built the first Neighborhood Health Centers and other community clinics were certainly successful in redefining health and health promotion in national conversations. Yet, while they made race and class central to these conversations, they did not emphasize inequities associated with sex, sexual identity, or gender.

In chapter 2 I recount the Seattle Women’s Liberation movement effort—organized by feminists in the University of Washington YWCA—to ensure that women living in Seattle, and traveling to Seattle from other parts of Washington State, surrounding states, and Canada would receive abortions in a safe and caring context. Washington State voters legalized abortion by referendum in 1970, making it one of a handful of states in the country with legal abortion before Roe v. Wade. Although nonresidents of the state could not legally acquire an abortion, many women still traveled for the procedure and needed assistance once they arrived in a strange city. University of Washington YWCA feminists organized the Abortion Birth Control Referral Service (ABCRS) to evaluate physicians willing to perform abortions and provide referrals to out-of-state abortion patients, women from rural parts of the state, and Seattle women who wanted an abortion but didn’t know whom to contact to obtain one.

Archival sources for this chapter include patient feedback forms provided by ABCRS to women to assess their abortion experiences. Volunteers at ABCRS used the feedback collected on the forms to appraise the performance of doctors, hospitals, and clinics providing abortions.
Yet, these feedback forms also provide a glimpse into abortion patients’ feelings about their abortions. Women were provided with a space on the form to discuss their attitude towards abortion and whether it changed after the procedure. These rich responses resonate with Andrea Smith’s findings that Native American women’s responses to questions about their position on abortion do not fit neatly into a “pro-life” or “pro-choice” category. Smith’s article focuses on the attitudes of Native American women and other women of color. Yet, the ABCRS feedback suggests to me that many women’s positions on abortion did not fit into discreet categories. The feedback forms collected by ABCRS did not indicate the racial or ethnic identities of the patients, but given the racial and ethnic demographics of Seattle, it is likely that the majority of women were white. It is imperative that we listen to women’s actual “voices” to understand how they felt rather than presume that attitudes towards abortion are neatly dichotomized.

Abortion provision in a safe and caring context was only one of the issues Seattle feminists addressed. University of Washington YWCA feminists also created a feminist women’s health clinic—named Aradia after the goddess of the healing arts—to increase women’s reproductive and sexual autonomy. In chapter 3 I tell how Women’s Liberation activists founded Aradia and ran the women’s health center to provide contraceptive care, preventive care such as cancer screening, and information about sex, sexuality, and relationships. Seattle feminists were cognizant of differences among women, particularly on the basis of race and class, that contributed to different health and reproductive care priorities. In order to increase women of color’s access to reproductive health care, YWCA feminists founded a Third World Women’s Resource Center and an affiliated clinic. They also coordinated a “Feminism and Racism Rap Group” at Aradia to discuss racism in the Women’s Liberation movement. These efforts contradict popular notions that white middle-class feminists focused exclusively on their own political demands without considering the different needs of women of color or poor women. Many white feminists were concerned about race and wanted to address their own racist impulses.

In chapter 4 I turn to the Atlanta Feminist Women’s Health Center, which opened in 1977. Like Aradia feminists, founders of the Atlanta Feminist Women’s Health Center (FWHC) hoped to provide feminist
and woman-controlled health services in a compassionate atmosphere. They provided forums in which women could learn about their bodies and discuss the relationship among body knowledge, sexuality, and health. Yet, unlike Aradia feminists in the first half of the 1970s, Atlanta feminists quickly encountered opposition from the anti-abortion movement. The Atlanta FWHC, like its predecessor the Los Angeles FWHC, provided abortions in addition to comprehensive gynecological services. (Aradia did not provide abortions until the 1980s.) Despite their attention to self-knowledge and collaborations among women to promote understanding of the body and sexuality, health centers associated with the Federation of FWHCs, such as the Atlanta clinic, also instituted a more structured system of providing medical care that included fixed fees and medical hierarchy.

Atlanta FWHC faced significant challenges from the anti-abortion movement just two years after opening their doors. A close look at anti-abortion movement confrontations in Atlanta helps us to better understand why feminists often made abortion central to their politics in the 1980s. It also sheds light on the strategies used by the anti-abortion movement: legislative and direct action tactics. Both legislative techniques and direct action campaigns took a significant toll on the Atlanta FWHC, making abortion provision more expensive and thus absorbing scarce resources that could have been spent on other women’s health problems. Threats of clinic bombings, harassment, and arson also had a psychologically draining effect on clinic workers. Still, Atlanta FWHC continued to provide abortions and other health services throughout the most intense periods of anti-abortion protest, including during the 1988 Democratic National Convention. HIV testing, in particular, was an important service offered by Atlanta FWHC. In 1987 they expanded their HIV work with the Women with AIDS Partnership Project, which targeted African American and poor women for testing, education, and health services since these groups of women were most vulnerable to HIV transmission and had less access to comprehensive health services.

The Atlanta FWHC struggled with a perception that they largely served the interests of white women, despite their attention to HIV/AIDS and its impact on women of color. Many women of color believed that the Atlanta FWHC and other majority-white feminist organizations displayed subtle forms of racial bias and even racism. In chapter
5, I spotlight the work of Loretta Ross within the National Organization of Women (NOW) in order to explore conversations about race and racism within majority-white feminist organizations focused on reproductive politics and abortion rights. As the director of Women of Color Programs, Ross worked to build coalitions between NOW and women of color organizations. She met with mixed success but eventually left NOW to work with Byllye Avery and the National Black Women’s Health Project. Ross believed that NOW continued to marginalize women of color, so, like other women of color activists interested in issues of women’s health and reproductive politics, she shifted her focus to independent women of color organizing.

Chapter 6, the concluding chapter of this book, details the creation of a reproductive justice movement among women of color. Critical of the dominant abortion rights discourse about reproductive “choice,” they used human rights as their frame for building a movement that focused on transforming the broad social and economic context that they believed was fundamental to achieving reproductive justice for all women. Distancing themselves from a medical model of health care activism, women of color feminists like Loretta Ross, Dázon Dixon Diallo, and Luz Rodriguez argued that fundamental needs—ending poverty, gaining access to jobs and quality housing, and acquiring education—all needed to be met in order to guarantee reproductive justice. Since poor women and women of color had the most trouble satisfying these most basic needs, they suffered compromised reproductive health and control over their reproductive choices. Thus, like the civil rights activists who insisted that economics and access to food were essential to health, women of color activists also insisted that when people are hungry, health care is food, jobs, and community empowerment. Demands to satisfy basic needs cannot be separated from reproductive politics, because a right to reproductive control is hollow without a right to live free of hunger, racism, and violence and without the dignity that facilitates real choices for one’s own future and community.