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Southern Women, Feminist Health:
Place, Politics, and Priorities in Five Feminist Women's Health Organizations in the Southeastern U.S., 1970-1995

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An abstract of
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Abstract

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By Hanne I. Blank

This project, *Southern Women, Feminist Health*, bears witness to the history and ongoing existence of feminist women's health organizations in the southeastern United States. By presenting case histories of five southeastern feminist women's health organizations between 1970 and 1995, this research proves that such organizations existed, and continue to exist, in a region they are sometimes thought not to have existed at all. This begins to fill a southern regional gap in feminist health historiography while also considering ways southernness might have influenced the specific ways feminist women's health developed in the southeastern United States, thus contributing to the interdisciplinary conversation on "southernness" and its meanings.

This study thus confronts the idea of southern distinctiveness, approaching it via the modalities of feminist historiography as a question of lived experience as well as through more external and objective measures, and argues that historical actors may have perceived their experiences as being distinctively southern, or as distinctively linked to southern histories. Simultaneously this study takes part in an emerging scholarship on southern feminist, queer, and Black lives which contends that regional distinctiveness must be evaluated in a context inclusive of regionalized oppressions. In doing so this project employs a "multiple Souths" sociogeographic model and five locations: Fayetteville, Arkansas; Tallahassee, Florida; Memphis, Tennessee; and two quite different versions of Atlanta, one Black and the other largely white.

This project firmly establishes the women's health movement as a phenomenon with a diverse and widespread southern presence, something lacking in the extant literature. It engages the hyperlocalized and frequently ephemeral nature of grassroots activism, allowing comparative views of ways local organizations manifest dynamics, goals, and ideologies of larger, national movements. This project argues that although feminist health activists shared some basic tenets of what feminist health could and should be, what activists attempted and realized was neither so uniform or so singularly focused on reproductive and sexual health as is often assumed. In these southern manifestations of the women's health movement, much depended on the activists' positionality—including location—as they struggled to create better health options for women.

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Introduction

"You'll have to forgive me for eavesdropping," the woman in the next chair at a Memphis nail salon interjected, "but I couldn't help overhearing that you're working on a project about the clinic, the women's clinic. Is that right?" I confirmed that it was, upon which the woman began to narrate her history as a volunteer at the Memphis Center for Reproductive Health in the 1980s. Overhearing this conversation, one of the receptionists wandered over and, as I sat having my toenails painted, started to tell *her* story of connection with the Center, beginning with getting an abortion there in the early 1980s and continuing on to volunteering with fundraising and providing clinic defense against right-to-life protesters. Before my mani-pedi was done that evening, three of the women who were, by happenstance, in the same nail salon at the same time in a medium-sized city in the south, had told me about their personal connections to the clinic I had come to their city to research. The Memphis Center for Reproductive Health, known as "Choices Memphis Center for Reproductive Health" at the time of my visit in early spring of 2017, might not have been mentioned anywhere in the extant literature about feminist women's health but it had been in business since 1974, and had clearly been an noteworthy presence and force in the lives of Tennessee women for decades. It was part of their reproductive lives, their healthcare lives, and their political lives. They had engaged with it as patients, as feminists, as parents of female children, and as members of its larger community. It was part of their history as self-identifying southern women, and they were, in turn, part of its history. It was one of those lovely moments of human synchronicity that sums up the *raison d'etre* of a research project.

This project, *Southern Women, Feminist Health*, was conceived in order to do precisely what these women in a Memphis nail salon did in sharing their personal histories with me so openly and eagerly: to bear witness to the history and ongoing existence of feminist women's health

organizations in the southeastern United States, showing that these organizations were (and in some cases still are) important parts of women's lives and worlds. This research shows definitively that these organizations existed, and continue to exist, in a region where they are sometimes imagined, particularly by those with an investment in seeing the southeastern USA as a bastion of retrograde conservatism, not to have existed at all. More specifically, this project presents case histories of five different southeastern feminist women's health organizations during their origin periods, typically the first five to ten years of operations, between 1970 and 1995. It does so with a view toward helping to fill out the southern tier of extant U.S. feminist health historiography and considering whether (and if so, how) southernness might have influenced the particular manifestations of feminist women's health that developed in the southeastern United States. These goals, which I have hopefully met, not only provide a significant addition to the existing literature but also interrogate and explore the deeply interdisciplinary and intersectional nature of "southernness" and what it can mean for and to historians.

The feminist women's health movement began as an offshoot of the so-called "second wave" of American feminism in the 1960s and 1970s.[1] Beginning in the mid-1960s, feminist consciousness-raising groups and activist organizations, seeking to create awareness of gender inequity and generate enthusiasm for combating it, created opportunities for women to have simultaneously intimate and politicized conversations about their lives, believing correctly that as the catchphrase made popular as the title of a Carol Hanisch essay put it, "the personal is political."[2]

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[1] The "waves" model of feminist historiography has, in recent years, come into considerable criticism, not least by Nancy Hewitt, whose essay "From Seneca Falls to Suffrage?: Reimagining a 'Master' Narrative in U.S. Women's History" neatly sums up the racist, eastern-seaboard-centric, and classist nature of the "waves" model. Nancy A. Hewitt, "From Seneca Falls to Suffrage: Reimagining a 'Master' Narrative in U.S. Women's History," in *No Permanent Waves: Recasting Histories of U.S. Feminism*, ed. Nancy A. Hewitt (New Brunswick, NJ: Rutgers University Press, 2010), 15-38. Also extremely influential in criticizing this model are Kathleen Laughlin and Jacqueline Castledine, eds., *Breaking the Wave: Women, Their Organizations, and Feminism, 1945-1985* (New York: Routledge, 2015) and Anneliese Orleck, *Rethinking American Women's Activism* (New York: Routledge, 2015).

[2] The phrase may be traced to the 1970 publication, in Shulamith Firestone and Anne Koedt, eds., *Notes from the Second Year: Women's Liberation* (New York: Radical Feminism, 1970) of Carol Hanisch's 1969 memo to the women's caucus of

These conversations revealed widespread and appalling sexism and injustice throughout American (and indeed world) society; feminist scholarly and journalistic analyses and exposes of a broad range of topics swiftly followed. All were instrumental to feminist community-building and political formation.

Through such feminist dialogue and analysis the realm of medicine and health care was revealed as a source of especially pernicious misogyny in action. As feminist health care "founding mother" Carol Downer asked—not at all rhetorically—in her 1972 address to the American Psychological Association, "Is the quality of women's health care lowered by the fact that the male half of the human race legislates, dictates, administrates, and implements health care for the female half of the human race? The answer is an emphatic 'Yes.'"[3]

Downer's line of questioning was also influenced by a broader context of New Left activism, including the Civil Rights movement, welfare rights activism, and an array of legislative attempts—the 1963 Equal Pay Act, the 1964 Civil Rights Act, 1965's Executive Order 11246 which initiated affirmative action -- to improve and democratize American society. Based in critical race, class, and gender analysis, the politics and philosophies that undergirded these societal changes also proved powerful in analyzing and understanding the ways in which members of minority groups were frequently systematically denied information and bodily autonomy by the majority-white, majority-male doctors who ran the mainstream medical establishment.[4] Downer and others came to

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the Southern Conference Educational Fund. Originally entitled "Some Thoughts in Response to Dottie's Thoughts on a Women's Liberation Movement," the text was retitled "The Personal is Political" by the editors of the 1970 publication. On her website, Hanisch disavows having created the phrase, although she is commonly credited with it in feminist lore and historiography. See http://www.carolhanisch.org/CHwritings/PIP.html, viewed January 2, 2019.

[3] Carol Downer, "Covert Sex Discrimination Against Women as Medical Patients," Address to the American Psychological Association, September 5, 1972. Atlanta Lesbian Feminist Alliance Archives collection, Medical and Reproductive Rights Series, Item ID wlmms01019. David M. Rubenstein Rare Book & Manuscript Library, Duke University.

[4] See Sandra Morgen, Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990 (New Brunswick, NJ: Rutgers University Press, 2002), 3-10; Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (New York: Praeger 1978), 60-64. Ruzek has a useful brief discussion of feminist women's health connections to the free clinic movement, the Medical Committee for Human Rights, and the Health

understand that it was no accident that it was commonplace that in some cases, women were medicated, treated, and at times even operated upon surgically without being given full information, and sometimes without their consent. Women were frequently belittled, dehumanized, and sometimes abused by doctors when they sought medical care, to the extent that it was customary at many medical schools for students to be taught to perform gynecological exams on the bodies of anaesthetized women who had not necessarily consented to their unconscious bodies being used as teaching dummies. The list of customary medical barbarities and inhumanities to which women were subjected is well-documented and long, and involved not only clinical and medical-educational but also research praxis. Indeed, even when it came to drugs that were exclusively prescribed to women, as in the case of the oral contraceptive pill, drugs were not always adequately tested nor were women given warnings of potentially serious side effects.[5]

By 1968, the first feminist-influenced health related legislative hearing, the so-called Nelson hearings on the safety of the contraceptive pill, took place before Congress. By 1971, health activists on opposite coasts had begun to create two different models of woman-centered, woman-controlled feminist alternatives to traditional health care. In Boston, a collective of women coalesced out of a feminist health consciousness-raising group and became the Boston Women's Health Book Collective, dedicated to producing health education materials by and for feminist women. *Our Bodies Ourselves,* first published in 1971, sold a quarter of a million copies via the feminist grapevine before it was expanded and republished by Simon and Schuster in 1973. The book has been continuously

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Policy Advisory Center (Health/PAC) in addition to connections to less radicalized streams of health and welfare reform.

[5] The literature on medical sexism and misogyny in the U.S. and elsewhere in the world is fairly extensive. As it is not my primary topic here I give a few representative titles: Jane Bauer Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* (Westport, CT: Greenwood Press, 1978); Rosemary Pringle, *Sex and Medicine: Gender, Power, and Authority in the Medical Profession* (New York: Cambridge University Press, 1998); and Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger 1978), 33-53.

in print since then and is currently in its fourteenth edition in worldwide distribution, available in 30 languages as of this writing.[6] [7] [8]

At the same time as *Our Bodies Ourselves* was first being compiled in Boston, Southern Californian feminist lawyer Carol Downer, having come to the realization that she had never seen her own cervix despite many other people's having seen it in the course of her six pregnancies, began an aggressive program of medical self-education. At a local NOW meeting in April 1971, Downer began to teach what became known as Self Help Clinic, demonstrating how women could conduct their own basic genital, vaginal, and cervical exams with the use of speculum, mirror, and flashlight. Downer's radical idea struck a nerve with women long deprived of meaningful medical self-knowledge, and soon women across the country were practicing and teaching these skills. Self Help Clinics became the prototype and the core of the mainstream (which is to say majority white and middle class) feminist women's health clinic movement, a movement devoted to the concept of health care controlled by women, responsive to women's experience, and supporting women's ability to be fully in control of their own health and lives.[9] [10]

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[6] Boston Women's Health Book Collective, "Our Bodies Ourselves History", http://http://www.ourbodiesourselves.org/history/, accessed April 10, 2015. See also Morgen, *Into Our Own Hands*, 16-22.

[7] In the spirit of full disclosure: I was a member of the large collective of authors and editors who worked on the most recent (2011) print edition of *Our Bodies Our Selves*.

[8] During the writing of this project, in April 2018, the collective responsible for creating *Our Bodies Ourselves* made the decision to discontinue publication and revision of the book, and in October 2018, transitioned to a volunteer-led women's health advocacy organization. See https://www.ourbodiesourselves.org/our-story/whats-new/, accessed December 14, 2018.

[9] Morgen, *Into Our Own Hands*, 22-26, 71-73; Ruzek, *The Women's Health Movement,* 53-57. See also Christine E. Eubank, "The Speculum and the Cul-de-Sac: Suburban Feminism in 1960s and 1970s Orange County, California" (Ph.D. diss., University of California, Irvine, 2013); Jenna Morvren Loyd, "Freedom's Body: Radical Health Activism in Los Angeles, 1963 to 1978" (Ph.D. diss., University of California, Berkeley, 2005).

[10] On the philosophical and bioethical ramifications of these feminist healthcare principles, see Margaret Farley, *Compassionate Respect : A Feminist Approach to Medical Ethics and Other Questions* (New York: Paulist Press, 2002); Sue Wilkinson and Celia Kitzinger, *Women and Health : Feminist Perspectives* (Bristol, PA: Taylor & Francis, 1994); Susan Sherwin and Feminist Health Care Ethics Research Network, *The Politics of Women's Health : Exploring Agency and Autonomy* (Philadelphia: Temple University Press, 1998); and Susan Sherwin, *No Longer Patient : Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

Significant feminist women's health activism, therefore, predated the landmark Supreme Court of the United States decisions on abortion, *Roe v. Wade* (1972) and *Doe v. Bolton* (1973). With these decisions, however, a new era dawned as some of the feminists already involved in other forms of feminist health care began to open women-controlled clinics that provided legal abortion. Carol Downer and Lorraine Rothman's Los Angeles Feminist Women's Health Center (LAFWHC) began to provide abortion services in 1973. By 1976, Sandra Morgen estimates, there may have been as many as 50 such feminist-run, woman-controlled clinics across the country.[11] These clinics shared commitment to a feminist ethos of providing financially and socially accessible medical care to women in a woman-controlled setting where the experiences and concerns of women patients were of paramount importance. To the greatest extent possible, women (both formally trained and laywomen) provided medical care and treatment to other women.[12] These clinics became the most visible public face of the feminist women's health movement.

This project has deliberately chosen to look at only the foundation periods of feminist health organizations, generally the first ten years of their existence (if they indeed lasted that long). There are two major reasons for this. First, organizations tend to change over time, and feminist organizations are no exception. As this project demonstrates, the vicissitudes of existing in a community and doing business as a health care provider were likely to have an influence on the degree of idealism an organization could sustain. Finances, and the tension between feminist ideology and the need to pay the bills, were another frequent source of conflict. Maintaining a health organization without the infrastructure of the mainstream medical establishment and its

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[11] Morgen, 71. Note that the roster developed in the course of this project has revised this estimate dramatically upward. See Appendix A.

[12] Three essential sources on the nature and history of the feminist health movement are, in order of their date of publication: Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978); Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick, NJ: Rutgers University Press, 2002); and Jennifer Nelson, *More Than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015.)

economies of both scale and reputation is surely not for the faint of heart, then or now. This brings up the second reason for examining the foundation periods of these organizations: they often did not survive long. But their longevity or lack thereof is not necessarily an indicator of their historical relevance: the ways in which women reimagined what health and health care might mean for themselves and their daughters proved far-reaching and transformative for American health care generally speaking, foregrounding issues of women's health education, autonomy, and equity in treatment and research.[13] Therefore, the simple fact that women attempted—alone or in community—to do the very difficult thing of creating and sustaining these organizations at all is meaningful. In order to get a sense of what these feminist health organizations initially intended to do, how they intended to do it, and how their priorities and activities meshed (or not) with the communities and places in which they operated, it is useful to look at the period during which these conflicts and negotiations began.

Only against this backdrop, however hastily sketched here, can we begin to assess what it might mean to talk about the feminist women's health care landscape within the U.S. south. But first: what is "the U.S. south"? Some sense of place is centered is crucial to historical discussions that implicate region, but how to define it? Political boundaries are malleable, and in any case are not necessarily or even coincidentally congruent with climatic regions or topographical features, cultural borders, or even shared histories. For the purposes of this study, I have chosen to follow the path of many historians and political scientists in opting for the historically resonant "Confederate states" model over the U.S. Census division model.[14] The Civil War and its aftermath (Reconstruction, Jim Crow, and Jim Crow's ardent defenders) tends to form the backbone, if not the functional delimiter,

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[13] See Afterword.

[14] The Confederate states are used as the working definition for "the south" in a majority of historical works on the south as a region, including Jeanette Keith, ed., *The South: A Concise History,* 2 vols., (Upper Saddle River, N.J.: Prentice Hall, 2002), which I chose as a reasonably recent touchstone reference.

of many historical discussions of "the south. " I thus join historians like James C. Cobb in continuing to use the Confederate states grouping for the purposes of historiographical work.[15]

At the risk of offending Confederate states model purists, however, I have chosen to omit Texas from the list of states I consider "southern" for the purposes of this project. Despite its strong ongoing feminist women's health presence, I have two reasons for leaving Texas out of my research. First, Texas' feminist and feminist health histories are deeply entwined with Latina/o culture, politics, and health histories. This set of issues and dynamics are not significantly present in the remainder of the southern states during the period under investigation, while African-American culture, politics, and black/white racial dynamics are. There is, of course, a vast and nuanced African-American history in Texas. However, in my cursory research on Texan feminist health histories, black/white dynamics did not appear with the consistency and vigor of Latina/White dynamics. This may or may not reflect the larger and deeper picture; considerable further research would be required to find out. For my purposes, however, it appeared that contending with the Latina/White dynamics characteristic to Texas' feminist health landscape would have required a significant shift in and expansion of my research, so I chose to limit my scope.

Furthermore, I omit Texas from my map of "the south" because Texas—or white Texas, at least—has a long history of considering itself *sui generis* in many ways, treasuring its identity as a maverick, self-defined state and a region unto itself, not part of a larger "south."[16] Omitting Texas from consideration as part of "the south" on the grounds of cultural nuance has precedence: sociologist John Shelton Reed's work on what he termed the "folk geography" of the south, echoed by the somewhat later efforts of Christopher A. Cooper and H. Gibbs Knotts, conclude that a

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[15] James C. Cobb, *Away Down South: A History of Southern Identity* (New York: Oxford University Press, 2005),

[16] For an analysis of how Texas history is incorporated into this cultural self-definition at the state level, see the chapter "Selling Texas: The Political Branding of Texan Cultural Identity" in Leigh Clemons, *Branding Texas: Performing Culture in the Lone Star State* (Austin: University of Texas Press, 2008), 95-119.

"southern" sociocultural affiliation is endemic to a core group of Confederate states but not to all, the outliers being Texas, Maryland, Delaware, and Washington, D.C. [17] [18]

This has great meaning for the concept of southern distinctiveness as it applies both to my historical subject and its human participants. Given the lengthy history of viewing the U.S. south as a place apart, distinctive in its culture, politics, and people, a study of feminist health organizations in the south must inevitably engage on some level with this commonplace contention and particularly with these historical actors' engagement with the idea of southern distinctiveness. It matters, in other words, whether or not those activists and organizers thought of themselves as being southerners or had an awareness of themselves as situated in "the south," whatever that might have meant to them.

Therefore, some of the questions that I ask in this research pertain not to southern distinctiveness as a matter of broad historical verities but, in a classically feminist mode of inquiry, as a matter of experience and response to experience.[19] What *did* "southern" mean to the women who created these health organizations? Did a southern location lead them to a distinctively southern variety (or varieties) of feminism, or of feminist health? Were there distinctively southern problems or obstacles faced by feminist health activists, or formative experiences they had in common?

Particularly given common presumptions—and historical documentation -- of southern cultural conservatism and backwardness, the political and social effects of Bible Belt religiosity, and the deprivations of regional endemic poverty, these things are worth considering. They are doubly so considering the historical (and present-day) substance given to such presumptions in work

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[17] John Shelton Reed, "The Heart of Dixie: An Essay in Folk Geography," *Social Forces* 54 no. 4 (1974): 925-939;.
[18] Christopher A. Cooper and H. Gibbs Knotts, "Rethinking the Boundaries of the South," *Southern Cultures* 16 no. 4 (2010): 72-88. Usefully, as well as evocatively, Cooper and Knott look at self-labeling within southern states using the words "Dixie" and "Southern" in order to rank those states as "southern to the core," "pretty darn southern," or "sorta southern." Texas, Maryland, Delaware, and Washington, D.C. did not qualify for inclusion in any of these categories.
[19] Joan Wallach Scott, "The Evidence of Experience," *Critical Inquiry* 17 no. 4 (Summer, 1991): 793-797.

including Angie Maxwell's *The Indicted South: Public Criticism, Southern Inferiority, and the Politics of Whiteness*; Darren Dochuk's *From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism;* Nicole Mellow's *The State of Disunion: Regional Sources of Modern American Partisanship;* and Ronald C. Wimberly's landmark study *The Southern Black Belt: A National Perspective*.[20]

Some historians including Joseph Crespino and Matthew Lattimer have argued, and convincingly so, that such geographically widespread phenomena as poverty, cultural conservatism, religiosity, racism, and so on can scarcely be considered grounds for claims of southern exceptionalism.[21] But it simultaneously remains true that historical actors may have perceived their experiences of living and working in the south as being distinctively southern in some way, or as directly, distinctively linked to southern histories. The archive makes it patently clear that this was true of many southern feminists, including health feminists.

For example, numerous feminist historical actors have spoken of Southern white masculinity as being in some ways distinctive, in their experience. They were capable of distinguishing it from other, non-southern examples of the same phenomena, and explaining what was different. This is surely subjective and limited in its scope, and yet it provides a good reason for the historian to at least entertain the possibility that a distinctively Southern white masculinity was a subjective reality for many.

For example, Linda Curtis, one of the founding mothers of the Tallahassee Feminist Women's Health Center (TFWHC), was quite explicit about the specific linkages she perceived between Southernness, masculinity, whiteness, and the behaviors of local physicians while also

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[20] Darren Dochuk, From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism (New York: W.W. Norton, 2011); Angie Maxwell, The Indicted South: Public Criticism, Southern Inferiority, and the Politics of Whiteness (Chapel Hill: University of North Carolina Press, 2014); Nicole Mellow, The State of Disunion: Regional Sources of Modern American Partisanship (Baltimore: Johns Hopkins University Press, 2008); Ronald C. Wimberly, The Southern Black Belt: A National Perspective (Lexington, KY: TVA Rural Studies Press, 1997).

[21] Matthew D. Lassiter and Joseph Crespino, eds. *The Myth of Southern Exceptionalism* (New York: Oxford University Press, 2010).

retaining an awareness that the patriarchy writ large oppressed women everywhere. In April 1976, Curtis gave a speech entitled "The Tallahassee M.D. Conspiracy" at the first Southeastern Women's Health Conference, a regionally-focused conference for health feminists that was convened in Gainesville on the campus of the University of Florida. Curtis did acknowledge that other women's health organizations were "under attack" in other parts of the country as well and that the power structures of the American Medical Association and the American College of Obstetricians and Gynecologists represented a potential obstacle to health feminism nationally. Yet she was unequivocal about what she perceived to be connections between perceptions of Southern inferiority and mistreatment of feminists by others in the feminist community and in the wider world, the South as "colonized" by white supremacist interests, and also an unbroken Southern legacy of white male capitalist exploitation and oppression Curtis described as stretching from the antebellum era to the present. Curtis painted this picture in order to suggest that the TFWHC's problems were but one manifestation of it.[22]

> "White male supremacists control the South's industry. This spills over and pollutes every other aspect of our economy including health care delivery. It is no coincidence that the South is the bastion of the AMA monopoly! Tallahassee's health system is a microcosm of the pervasive system of control that the AMA now has on this country's health system. ...In Tallahassee, Blacks have had to fight to get on staff at the only hospital in the county, Tallahassee Memorial Hospital. Unionization at TMH has failed due to the very tight control of workers that exists in the South. Individuals who have tried to set up clinics have not been able to succeed. A few years ago some of the same MDs that we're suing managed to close down the Public Health Department's pre-natal clinic. …Women in

[22] Linda Curtis, "The Tallahassee MD Conspiracy," lecture given at the First Southeastern Women's Health Conference, Gainesville, FL, April 3, 1976. Papers of the Women's Community Health Center (Cambridge, MA), Box 15a, The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute, Harvard University.

> Tallahassee…have resorted to giving birth without any assistance. They have been driven to using the TMH emergency room like an outpatient clinic and seek out the FWHC's services as a welcome improvement over previously existing conditions."[23]

In this talk, Curtis also referenced the anti-Southern prejudices of non-Southerners, noting that people elsewhere were "convinced that Southerners are so inherently racist and stupid that a New York radical feminist recently succumbed to this regionalist bias by trying to deride some women writers for "living and dying in Dixie" as if that was the worst thing that could happen to them!" and continued, impassionedly arguing that "it is imperative that the women's movement understand this and rid the movement of regional bias that leads us to believe that feminist struggle should take place "where the action is," supposedly in non-Southern urban areas."[24] If nothing else, being mocked and disregarded by feminists for one's southernness is a distinctively southern feminist experience!

Considering southern distinctiveness as potentially inclusive of regionalized oppressions, regionalist prejudice, and of subjective experiences of those oppressions is a subject currently being explored in an emerging scholarship on southern feminists, feminisms, and queer and black lives. In the past few years, for example, E. Patrick Johnson's pair of oral histories, *Black. Queer. Southern. Women: An Oral History* and *Sweet Tea: Black Gay Men of the South* have given historians of the recent southern past much to think about with regard to whose histories might be considered distinctive or exceptional, and what an intersectional approach to historiography has to offer when it comes to considering these questions of "distinctiveness" or "exceptionalism."[25] So too Jaime Harker's *The Lesbian South: Southern Feminists, the Women in Print Movement, and the Queer Literary Canon*, which

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[23] Ibid., 4.

[24] Ibid.

[25] E. Patrick Johnson, *Black. Queer. Southern. Women.: An Oral History* (Chapel Hill: University of North Carolina Press, 2018); E. Patrick Johnson, *Sweet Tea: Black Gay Men of the South: An Oral History* (Chapel Hill: University of North Carolina Press, 2011).

chronicles the ways in which southern lesbian feminists deliberately took their southernness as distinctive and made it exceptionally productive as a radical, transgressive, sexually and politically liberatory location through literary work and institution-building around books and writing.[26] It is additionally worth noting that the products of this southern lesbian feminist literary movement, including the journals *Feminary* and *Sinister Wisdom*, were (and remain) highly influential repositories of women's culture and history in the south; *Sinister Wisdom*, in collaboration with the Sallie Bingham Center for Women's History and Culture at Duke University, continues to create its growing library of southern lesbian-feminist oral "herstory" interviews.[27] Last but not least is the growing and critically acclaimed literature, primarily written by black historians, dealing with the regionally and locally distinctive products of layered southern legacies—of race, culture, countercultures, and politics. Monographs such as like Zandria Robinson's *This Ain't Chicago: Race, Class, and Regional Identity in the Post-Soul South* and Keith Wailoo's award-winning contemporary classic, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health*, raise many questions about the distinctiveness of southern history and experience for people of African descent, and the variety of blind spots white historians have inevitably exhibited in this regard.[28]

It is with a view toward participating in this nuanced and deeply intersectional historical investigation into the question of southern distinctiveness that the current project takes the stance that although feminist women's health does not necessarily take on a distinctively southern manifestation in the southeastern U.S., it is simultaneously unnecessary to declare that there are no

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[26] Jaime Harker, The Lesbian South: Southern Feminists, the Women in Print Movement, and the Queer Literary Canon (Chapel Hill: University of North Carolina Press, 2018).

[27] See e.g. the online archive of oral history interviews available online at http://www.sinisterwisdom.org/SW93Supplement. Sinister Wisdom 93 / Southern Lesbian-Feminist Herstory Supplement, http://www.sinisterwisdom.org/SW93Supplement, viewed December 31, 2018.

[28] Zandria F. Robinson, This Ain't Chicago: Race, Class, and Regional Identity in the Post-Soul South (Chapel Hill: University of North Carolina Press, 2014); Keith Wailoo, Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health (Chapel Hill: University of North Carolina Press, 2001).

distinctively southern aspects, orientations, or events to be found in its history. As a feminist and anti-racist historian, I contend—siding with Marisa Fuentes as an important recent voice -- that it is critical to consider the problem of "power in the production of history" and the epistemic violence that results when the archival and historical record necessarily documents only (or even merely primarily) the experiences, worldviews, and priorities of dominant groups.[29] In doing so I am, as an historian, willing not only to listen to, but to believe, attempt to integrate, and at times to prioritize the voices of women, people of color, the LGBTQIA+-identified, and other historically marginalized peoples when they tell me what they have experienced.[30] These stories both may and may not align with hegemonic narratives, sometimes doing both within the same narrative. Given that the historically marginalized not only share space and resources with their dominators but are generally compelled to live within and use the same rhetorics and structures of power, is every reason that this should be so. This makes it doubly important to me, as a feminist historian, to abide by Clare Hemmings' suggestion to "pay attention to the *amenability* of our own stories, narrative constructs, and grammatical forms" to discursive and analytical structures which "we might otherwise wish to disentangle ourselves from if history is not simply to repeat itself."[31]

Therefore, in choosing the five organizations whose histories are surveyed in this project, I deliberately sought to survey multiple locations and experiences among feminist health organizers, communities, and organizations. Some of the organizations were failures, others successes. They were clinical and non-clinical, and their services ranged from simply providing information to performing abortions. Some focused on women of color, others on "women" writ large. The word

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[29] Marisa J. Fuentes, *Dispossessed Lives: Enslaved Women, Violence, and the Archive* (Philadelphia: University of Pennsylvania Press, 2016), 5-8.

[30] "other historically marginalized peoples" being groups including but not limited to: those with physical or mental impairment or disability, those belonging to minority religious groups, immigrants, the unhoused, the nomadic, indigenous peoples, members of diasporic cultures, the institutionalized, and so on.

[31] Clare Hemmings, *Why Stories Matter: The Political Grammar of Feminist Theory* (Durham: Duke University Press, 2011), 2. Emphasis in the original.

"feminist" might appear in their organizational name, or it might not. The organizations surveyed in this project additionally come from four different southern places, and arguably from five different souths.

The concept of multiple souths—the idea that "the south" as a unified and distinctive region is notional but that coherent cultural, social, and political regions within the broad southeastern geographical quadrant of the U.S. are demonstrable—has gained currency in contemporary historiographical approaches to the south as part of a larger discussion on southern history, identity, and distinctiveness.[32] This project therefore encompasses a sampler of souths. It includes the western Ozarks south of Fayetteville, Arkansas; the northern Floridian south of Tallahassee, Florida; the urban mid-south of Memphis, Tennessee; and two quite different versions of big-city Atlanta south, one emphatically black and the other largely (somewhat obliviously) white. This project assesses the existence of multiple feminist health organizations across a broad and variable region, noting relationships between organizations and region as they appear. These connections between location and organization range from observing the profound importance of Atlanta as a location attracting and supporting progressive Black thought and activism, which in turn enabled the creation and growth of the National Black Women's Health Project, to registering the influences of rurality and back-to-the-land politics on Fayetteville, Arkansas feminists' attempts to organize around feminist health.

Looking at manifestations of the feminist women's health movement in these variegated southern locales serves several functions, and intervenes in the current historiographical discussions

[32] This approach has been taken in a number of works since the 1990s, for example Robert T. McKenzie's *One South or Many? Plantation Belt and Upcountry in Civil War-Era* Tennessee (New York: Cambridge University Press, 1994); J. William Harris, *Deep Souths: Delta, Piedmont, and Sea Island Society in the Age of Segregation* (Baltimore: The Johns Hopkins University Press, 2003); Waldemar Zacharasiewicz, ed., *The Many Souths: Class in Southern Culture* (Tübingen: Stauffenberg Verlag, 2003), and Pippa Holloway, ed., *Other Souths: Diversity of Difference in the U.S. South, Reconstruction to the Present* (Athens, GA: University of Georgia Press, 2008). Further attesting to the influence of this model, "The Many Souths" was the theme of the 2013 Southern Labor Studies Association conference held in New Orleans, Louisiana.

of the late twentieth-century women's health movement in several ways. First and foremost, it firmly establishes the women's health movement as a phenomenon with a southern presence , something largely lacking in the extant literature. The historiography does not give much evidence of a feminist women's health movement in the southeast beyond the Atlanta Feminist Women's Health Center and occasional mentions of two clinics in Gainesville and Tallahassee.

In some ways this is quite understandable, since movement-produced writings such as *How to Stay Out of the Gynecologist's Office,* produced by the southern California-based Federation of Feminist Women's Health Centers (FFWHC) in 1981 also scarcely mentions the presence of southeastern organizations.[33] Sheryl Burt Ruzek's 1978 dissertation-turned-book, *The Women's Health Movement: Feminist Alternatives to Medical Control*, however, gives a list of 23 southern women's feminist health organizations in its appendices.[34] This tantalizing hint that there had once been much more than was reflected in later historical work indicated that at least part of the research required for this project would be lie in uncovering what women's health organizations had in fact existed in the southeastern states. Simply filling in some of this missing data helps to expand and enhance the historical picture. The Appendix of this dissertation, "Some Southern Women's Health Organizations and Abortion Providers, 1970-1995," presents a list of every southern women's health organization or abortion provider of which I found evidence during my research, nearly a hundred in all and thus a fourfold increase over those represented elsewhere in the literature. While this

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[33] Ironically, this is true here despite several southern clinics, including Tallahassee and Atlanta, having been members of the FFWHC and contributors to the book. Even if the California clinics from which the FFWHC emanated had been unfamiliar with the extent of the movement's presence in the south, and there is no reason to think that it they were, its southern affiliates were exceptionally well-connected and well-informed about their Californian sister organizations and projects, and were in regular communication Papers of the Atlanta FWHC housed at Duke University, in fact, show that the Atlanta FWHC both received start-up aid from the California FWHCs and later aided the Chico (CA) clinic financially. The failure to mention the southern feminist health presence in this source, in other words, affirms a coastal and urban movement orientation in which the south was viewed (for whatever reasons) as less important or unimportant.

[34] Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (New York: Praeger, 1978).

project deals in detail with only five of these, it is to be hoped that this list will prove useful to provide direction for future researchers and in simply presenting a material rebuttal to commonplace assumptions that neither feminism, feminist health, or abortion provision ever established a healthy and widespread presence across the southeastern USA.

There are two other significant boundaries I have chosen for this project that materially affect its content. First, the list of organizations at the core of this project does not include Planned Parenthood Foundation of America (PPFA) affiliate clinics. "Planned Parenthood" is a 1942 renaming of the American Birth Control League, which was founded in 1921 by Margaret Sanger. Although the organization has come to share many of the priorities of the feminist health movement of the 1970s and 1980s, it did not originate there. Nor have Planned Parenthood affiliates historically welcomed avowedly feminist-identified health activist organizations. The papers of the Atlanta Feminist Women's Health Center, for example, bear evidence of a contentious relationship between Atlanta's Planned Parenthood clinic and the AFWHC in which the PPFA clinic, first in 1976 and again in 1980, demanded the right to physically inspect and dictate terms to the feminist health center in exchange for the possibility of referring patients to AFWHC, clearly situating themselves as being superior to the feminist clinic in a manner not unlike that of the state insofar as they claimed regulatory authority.[35] If the spread of feminist women's health activism in the South was sufficient to pique the territorial instincts of an organization like PPFA, then there are certainly reasons to consider them as separate forces for the purposes and timeframe of this project.

Second, the project's chronological parameters are worth explaining. The start date for the study (1970) marks a midpoint between the two events often cited as being originary to the feminist

[35] Correspondence between Atlanta Feminist Women's Health Center and Planned Parenthood of Atlanta, June-September 1976, private collection of the Atlanta Feminist Women's Health Center, viewed May 2014; Atlanta Feminist Women's Health Center, Planned Parenthood of Atlanta, and Medical Association of Atlanta January-March 1980, Atlanta Feminist Women's Health Center papers, Box 101, Sallie Bingham Center for Women's History and Culture, Duke University.

women's health movement, the organizing of the group of feminists that ultimately produced *Our Bodies Our Selves* in Massachusetts in 1969 and Carol Downer's earliest self-help demonstrations (solo and with Lorraine Rothman) in California in 1971. It is fair to say that 1970 seems to have represented a sort of tipping point in terms of the coalescing of a feminist women's health philosophy and a concomitant set of bioethical imperatives, and that these were promptly manifested in the actions of multiple activists.

The end date, 1995, is a somewhat but not entirely arbitrary choice. With the emergence of HIV/AIDS as an epidemic in the late 1980s, feminist health services often experienced a high demand for HIV-related services and scrambled to meet this new need. Because of their social justice orientation, broad acceptance of gay and lesbian individuals, and in many cases long-term connections to LGBTQI community, feminist health organizations often willingly took up the task of providing care to HIV+ individuals at a time when such people frequently found it difficult to find any health care providers willing to touch or treat them.[36] This was particularly true for women with HIV/AIDS, as most of the early programs for HIV/AIDS concentrated on gay men. Thus there was (at least for a time) a way in which HIV/AIDS care represented a legitimately feminist extension of women's health priorities. Then in 1990 Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act, the first legislative act to make federal funding available for HIV-related care. Ryan White Act funding dramatically altered the landscape, encouraging dramatic growth and enhanced availability of HIV/AIDS focused healthcare, without making any more funding available for women's health or reproductive health.[37] In this and

[36] See Jon-Manuel Andriote, "Five Crises: A Brief History of ASOs," *The Gay and Lesbian Review* (May 2011): 21-23; Lisa Diedrich, "Doing Queer Love: Feminism, AIDS, and History," *Theoria* (April 2007): 38-39; and Joe Wright, "'Only Your Calamity': The Beginnings of Activism by and for People With AIDS," *American Journal of Public Health* 103 (2013): 1788–1798.

[37] See Kevin M. DeCock, Harold W. Jaffe, and James W. Curran, "Reflections on 30 Years of AIDS," *Emerging Infectious Diseases* 17/6 (June 2011): 1044-1048; and Steven Epstein, "Sexualizing Governance and Medicalizing Identities: The Emergence of 'State-Centered' LGBT Health Politics in the United States," *Sexualities* 6 (May 2003): 131-171.

numerous other ways, the overwhelming urgency of the HIV/AIDS epidemic overshadowed the work of the feminist women's health movement, which by this time was also seriously besieged by an increasingly militant anti-abortion movement and by industrial healthcare cooption of "women's health" motifs.[38] 1995 thus furnishes a sort of natural moment of punctuation in the history of the national feminist women's health movement.

These choices, by which I mean the specific organizations on which I chose to focus, their locations, and the time frame in which I chose to work, also in and of themselves constitute what I hope is a productive intervention in the literature. The diffuse, hyperlocalized, and frequently ephemeral nature of activism at the grassroots demands comparative views, if historians are to achieve some sense of the forces affecting how grassroots organizations do and do not participate in the dynamics, goals, and ideologies of the larger, national movements of which they are nominally part..

Developing some way to apprehend and integrate broad variability into our understanding of national political movements is critical. This is true not just along lines of race, class, or other divisive demographics within movements, as feminist and women's health histories by Winifred Breines, Jennifer Nelson, and Kimberly Springer have shown.[39] It is also true along the axis of place. As scholarship by Stephanie Gilmore, Judith Ezekiel, and Finn Enke has demonstrated, what much of the feminist historiography has characterized as typical and relevant in regard to so-called "second wave" feminism was in reality typical only to particular places and moments, notably the

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[38] Sandra Morgen, "The Dynamics of Cooptation in a Feminist Health Clinic," *Social Science & Medicine* 23 vol 2 (1986): 201–10; Carol S. Weisman, *Women's Health Care: Activist Traditions and Institutional Change* (Baltimore: Johns Hopkins University Press, 1998).

[39] Winifred Breines, The Trouble Between Us: An Uneasy History of White and Black Women in the Feminist Movement (New York: Oxford University Press, 2006); Jennifer Nelson, Women of Color in the Reproductive Rights Movement (New York: New York University Press, 2003); Kimberly Springer, Living for the Revolution: Black Feminist Organizations, 1968-1980 (Durham: Duke University Press, 2005). Also very worth including in this list is Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez, Undivided Rights: Women of Color Organize for Reproductive Justice 2nd ed. (Chicago: Haymarket Books, 2016), particularly its opening chapters.

northeastern seaboard and the large cities of coastal California, particularly Los Angeles and the San Francisco Bay Area.[40] It has been well established that this is due in large part to influential early chronicles having been written by northeastern and Californian movement participants like Jo Freeman, Ellen Willis, and Ruth Rosen, and also in part to other histories dependent upon the same coastally-oriented primary sources.[41] Alice Echols' *Daring to be Bad: Radical Feminism in America, 1967-1975,* for example, contends that coastal groups, particularly those in the northeast, "were the groups that made significant theoretical contributions," in spite of the well-known fact that the so-called "Florida Paper," authored by Judith Brown in Gainesville in 1968, circulated by hand from woman to woman, was key to galvanizing not just the first national Women's Liberation meeting but also hundreds of consciousness raising groups nationwide.[42] [43]

As the works cited above suggest, it has only been since the turn of the millennium, with the coming-of-age of a generation of scholars of an age to be the daughters of these 1960s and 1970s activists, that the scholarship has begun to question just how typical those "typical" feminist organizations chronicled in (for example) Freeman's, Rosen's, and Echols' histories really were. As a member of this generation, I have—perhaps predictably—joined this historical conversation, hoping to help historians achieve a more complete visualization of the ways it matters where the localized manifestations of a national movement exist.

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[40] A. Finn Enke, *Finding the Movement: Sexuality, Contested Space, and Feminist Activism* (Durham: Duke University Press, 2007) concentrates on feminist community institution-building in Detroit, Michigan. Judith Ezekiel's pioneering *Feminism in the Heartland* (Columbus: Ohio State University Press, 2002) deals with feminist movement work and activism in Dayton, Ohio. Stephanie Gilmore, *Groundswell: Grassroots Feminist Activism in Postwar America* (New York: Routledge, 2013) traces and compares the activities of NOW chapters in Memphis, TN; Columbus, OH; and San Francisco, CA.

[41] Jo Freeman, The Politics of Women's Liberation: A Case Study of an Emerging Social Movement and its Relation to the Policy Progress (New York: Longman, 1975); Ruth Rosen, The World Split Open: How the Modern Women's Movement Changed America (New York: Viking, 2000); Ellen Willis, Beginning to See the Light: Pieces of a Decade (New York: Random House, 1981).

[42] Alice Echols, *Daring to be Bad: Radical Feminism in America, 1967-1975* (Minneapolis: University of Minnesota Press, 1989) 20-21. On the Florida Paper, see "The Florida Paper," *Radical Women in Gainesville*, George A. Smathers Libraries, University of Florida Digital Collections, http://ufdc.ufl.edu/rwg/floridapaper, viewed December 28, 2018.

[43] Indeed, Carol Hanisch's memo published under the title "The Personal is Political," previously discussed in this chapter, was also written in Florida. See http://www.carolhanisch.org/CHwritings/PIP.html, viewed January 2, 2019.

As such I contend, along with fellow scholars Enke, Gilmore, and Ezekiel, that the particulars of manifestations of the national feminist movement are very much related to their local and regional contexts as well as to their moment relative to the development of the larger movement. I argue that although feminist health activists shared some basic tenets of what feminist health could and should be, the precise dimensions of what they attempted and were able to realize, organizationally speaking, were neither so uniform or as necessarily focused on reproductive health as we might imagine. Much depended on who was involved and where their involvement took place.

The regionality, specificity, and indeed, the southernness of my five case studies affected my research and methodology. There is, as discussed previously, not a great deal of coverage of southern feminist health in the extant literature. Because the lion's share of feminist women's health organizations have disappeared from the U.S. since 1980, this issue is somewhat more pressing than it might appear. In particular, the issue of historical preservation and thus of archiving has a certain urgency for historians of feminist health. Despite the recentness of the movement's heyday, the discovering feminist women's health organizations can be a needle-in-a-haystack affair, more happenstance than anything: I discovered the Mari Spehar Health Education Project thanks to a one-line reference in another health organization's newsletter. Some feminist women's health organizations, particularly national organizations like the National Women's Health Network and chapters of national organizations such as the NARAL Pro-Choice America (formerly the National Abortion Rights Action League) are well represented in formal archives. But most grassroots feminist health organizations are not. Such archival underrepresentation of feminist health organizations is a national problem. Yet a look at the organizations that have been formally archived reveals a telling pattern, namely that there are a number of obstacles to archiving feminist women's health that are endemic to the movement (and indeed to other grassroots activist

movements as well): ephemerality, awareness of and access to archives, mission and scope, legality, and privacy and safety concerns.

First, ephemerality: Organizations that survived longer and/or produced a more sizeable paper trail are more likely to be detectable in the formal, institutionalized archives. The vast majority of feminist women's health organizations, however, simply did not survive for long, and the somewhat improvisatory and typically deprofessionalized nature of many organizations did not produce a tendency to robust documentation. The importance of record-keeping was not necessarily much on the minds of women struggling just to find the money, time, and volunteer effort to hold weekly clinic nights or staff a phone-in question line.

To this, we can add the matter of archival access and awareness of the importance of formal archiving on the part of the historical actors. Women's health organizations from the northeastern U.S. appear to be overall better represented in the archive than organizations from other regions of the country. The region's historic density of institutions of higher learning, particularly those focused on and devoted to women and with woman-focused archives such as the Sophia Smith Collection (founded in 1942 at Smith College) and the Schlesinger Library on the History of Women in America, (founded in 1965 at Radcliffe College, now Radcliffe Institute for Advanced Study of Harvard University), no doubt accounts for at least some of that. So does the tendency for northeastern U.S. feminists to have been college educated white women who had begun to recuperate the history of their foremothers and were also developing an awareness of their contemporary movement's historicity.[44]

The hegemonic power structures of higher culture and education, of course, predisposed these historical projects toward the reproduction of values of whiteness, cisgenderedness, and

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[44] Lara Leigh Kelland, *Clio's Foot Soldiers: Twentieth-Century U.S. Social Movements and Collective Memory* (Amherst, MA: University of Massachusetts Press, 2018), 71-80.

heteronormativity, along with a focus on printed (or at least written) media, as is still often the case. Some feminists, particularly multiply-marginalized feminists, had enough sense of their own sociocultural importance and of the archive's likelihood of ignoring them that they exhorted other multiply-marginalized feminists to document their own histories, lest their own lives be writ in disappearing ink. As Black lesbian-feminist sisters, activists, and academics Barbara and Beverly Smith wrote in their 1978 "I Am Not Meant to Be Alone and without You Who Understand: Letters from Black Feminists, 1972-1978," there was "no guarantee that we or our movement will survive long enough to become safely historical. We must document ourselves now."[45]

Yet self-documentation, and memorializing the women's health movement as it took place, was only sometimes a political priority for feminists in the way the Smith sisters suggest it should by rights have been. This is in part a consequence of the prioritization and valorization of women's own experience, what Adrienne Rich described in *Of Woman Born* as each woman being the "presiding genius" of her own life.[46] The prioritization of women's experience as an authoritative form of knowledge contributed both to a tendency toward documentation and distribution of experiences, as in the case of the Boston Women's Health Book Collective and *Our Bodies, Our Selves*, but simultaneously to a deliberate preference *against* creating documentation on the grounds that the sharing and gathering of knowledge and experience among and between women was more important than writing it down.[47] Consciousness-raising and self-help gynecology groups, for example, were predominantly concerned with the generation of experiential knowledge for their members, but did not tend to generate documents. The very private and personal nature of their

[45] Barbara Smith and Beverly Smith, "I Am Not Meant to Be Alone and without You Who Understand: Letters from Black Feminists, 1972-1978" *Conditions* 4 (Winter 1978), 62-77.
[46] Adrienne Rich, *Of Woman Born: Motherhood as Experience and Institution*, 10th anniversary ed. (New York: W. W. Norton, 1986), 39.
[47] Wendy Kline, Bodies of Knowledge: Sexuality, Representation, and Women's Health in the Second Wave (Chicago: University of Chicago Press, 2010), 14-17.

activities, and the things disclosed by their activity, meant that written records were unlikely even had documentation been more of a priority. When such groups appear at all in the archive, it is often as an event listing in a newsletter or a mention in some piece of correspondence. Oral history may be the only method by which to recuperate any of what went on in particular groups, and that only if suitable subjects reveal themselves.

Issues of legality and safety also complicate the relationship of the women's health movement and formal archiving. The archival record of the famous Chicago abortion collective known as "Jane," for instance, consists of oral history interviews conducted in 1980 by University of Illinois at Chicago sociologist Pauline Bart, well after the *Roe v. Wade* decision that rendered abortion legal in 1973. "Jane" provided over ten thousand safe but entirely illegal abortions prior to *Roe,* making its members *de facto* criminals; Bart's interviewees are thus identified only by initials.[48] Since the legalization of abortion, the rise of an aggressive and sometimes violent anti-abortion movement has necessitated that abortion providers, including feminist women's health movement providers, to engage in an array of self-protective and security practices. At the clinical level, this might have taken the form of hiring security guards, implementing intercom and buzzer systems for entry, and developing good working relationships with the F.B.I. At the organizational level, security has often looked like keeping not only clinical records but organizational papers completely private and out of the public reach. Legal and safety risk were implicated in the record-keeping decisions of smaller, less formal groups as well. Two of my oral history informants specified, with emphasis on the fact that they did not wish to be identified as the suppliers of this information, that in groups in which they took part in self-help gynecology, herbal medicine, or menstrual extraction with other women, written records were deliberately and expressly forbidden due to the risk that members of the group

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[48] Jane Abortion Collective oral history collection, Special Collections and University Archives, University of Illinois at Chicago, https://findingaids.library.uic.edu/sc/MSJACO89.xml, accessed December 31, 2018.

(or the group as a whole) might be publicly exposed, and from there possibly charged with anything from indecent exposure to practicing medicine without licensure. It is noteworthy that even forty to fifty years after these subjects engaged in these activities they were still leery of the potential consequences of revealing that they did so.

Institutional relationships among feminist health organizations, very much including historically-based inter-institutional grievances, also appear to have had a decisive influence on the presence of feminist health organizations in the formal archive. Some of the organizations whose papers I attempted to review for this project, such as the Center for Black Women's Wellness, which began its life as an offshoot of the National Black Women's Health Project [NBWHP], categorically refused to consider allowing a historian access to their internal holdings. I would later discover, thanks to a conversation with former NBWHP administrator and longtime reproductive justice chronicler Loretta Ross, that the archival presence of both organizations has been compromised due to the actions of organizational leaders who have discarded, hidden, or withheld records.[49] While earlier records of the project and its founding mothers are housed at the Sophia Smith collection at Smith College, little is available in that collection that dates from later than the early 1990s. As the history recounted in this project shows, the early 1990s were a period of great strife and thoroughgoing transition for the National Black Women's Health Project. It is impossible, of course, to know exactly what is missing, although we can perhaps guess at why: as William Faulkner famously wrote in *Requiem for a Nun*, "The past is never dead. It's not even past."[50] The aliveness of the recent past, while promising the historian the prospect of bodies of evidence not yet grown cold, can also include deliberate and vigorously maintained silences.

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[49] Loretta Ross interviewed by Hanne Blank, November 8, 2016.

[50] William Faulkner, *Requiem for a Nun* (New York: Vintage International / Vintage Books, 2011), 73.

The result, in terms of the current state of the formal or "traditional" archive on feminist health, is a patchy situation with distinct gaps that may or may not, at this point, be fillable. The historiographical upshot of this archival situation is that, as is typical of historical writing generally speaking, the best-documented feminist health organizations are invariably those with the most robust and accessible formal archival presence. In the case of feminist health, this means that only one southern organization, the Atlanta Feminist Women's Health Center, has been the subject of multiple historical engagements to date, a direct consequence of its exceptional archival accessibility.[51] The AFWHC's papers are housed, thanks to the efforts of many people (of whom I, in the interests of disclosing any potential conflict of interest, am one), in the Sallie Bingham Center for Women's History and Culture at the David M. Rubenstein Library and Archives at Duke University.[52] In this it has up until very recently been an outlier, although one of the productive by-blows of the present research has been that I have introduced some other southern feminist women's health organizations to the archival possibilities of the Sallie Bingham Center, so there is at least a little change on the horizon in regard to the formal archival representation of southern feminist health organizations.[53]

Building these relationships, and indeed being given any access whatsoever to some of the private papers and private individuals that have influenced this project, has been due in part to my own personal extra-academic identity and life experience. As a feminist activist

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[51] Substantive historical treatments of the Atlanta Feminist Women's Health Center exist in Sandra Morgen's *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (Piscataway, NJ: Rutgers University Press, 2002) and Jennifer Nelson's *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015).

[52] I spent a not inconsiderable portion of the summer of 2015 laboring as a volunteer to prepare over a decade of the Atlanta Feminist Women's Health Center's privately-held records for transfer to the archives at Duke. The AFWHC, in a period of transitioning directorships, allowed me research access to its internal papers on the condition that I would get them ready to be taken to the archives.

[53] In particular, I was the point of connection between the Choices Memphis Center for Reproductive Health and the Duke University Libraries, a relationship which has already borne some archival fruit.

with involvements in LGBTQIA, radical body acceptance, reproductive autonomy, and other activist communities, it would be remiss of me to fail to acknowledge the ways in which this positionality, including my connections within activist communities and my reputation as a popular feminist writer helped me access people, papers, and organizations. Thanks to both reputation and connections, I was given access to many private papers, personal narratives, and, critically, a number of unarchived and unpublished oral history interview recordings and transcripts conducted by other researchers. This was particularly relevant in the case of the Mari Spehar Health Education Project. Allyn Lord, the director of the Shiloh Museum for Ozark History and a historian of Fayetteville, Arkansas' feminist and lesbian-feminist past, exhibited unparalleled queer scholar-sisterly generosity in permitting me the use of a number of transcripts from the 68 interviews she and collaborator Anna Zajicek conducted between 1996 and 1999 for their *The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970-2000*.[54] I do not claim, per strong proponents of standpoint theory, that my positionality affords me a superior or even an overall less biased analytical position, although at times it may provide greater cognizance of the contextual relevance of particular pieces of knowledge.[55] Nevertheless, and speaking specifically as a feminist historian whose politics include a desire to acknowledge the advantages conferred by identity and social position, I wish to acknowledge that my feminist and queer positionality has granted me atypical access to research resources on a subject where that atypical access has improved my ability to make original contributions to the historiography. It is my hope that this access not only enables me to make a historiographical stand for the widespread presence of feminist women's health

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[54] Allyn Lord and Anna M. Zajicek, The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970-2000 (N.P., 2001). Collection of the author.

[55] See e.g. Sandra Harding and Merrill B. Hintikka's introduction to Sandra Harding and Merrill B. Hintikka, eds., *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies* (New York: Routledge, 2004), 1-16.

organizations and organizers in the American southeast, but also make an important point about the southern movement's range and diversity.

Chapter One, "Feminists vs. Doctors," chronicles the origins of the Tallahassee Feminist Women's Health Center and its ultimate, if compromised, victory over a group of local physicians in a federal anti-trust lawsuit. As a new feminist medical presence made itself felt, the good old boy medical establishment used both overt and covert tactics to defend itself against what it perceived as pernicious and unqualified interlopers. Tallahassee physicians , as well as its only hospital, brought regulatory and professional weight to bear against the Tallahassee Feminist Women's Health Center, but if they anticipated a quick feminist retreat, they had not bargained on the Tallahassee feminists' willingness to lawyer up. The ensuing federal anti-trust suit was a winning attempt to remove the case from the reach of southern judges who might sympathize with the all-male physician old guard, and place it in the hands of federal judges who knew which way the Carter-administration deregulationist wind was blowing. In learning to view itself not only as a venue for feminist ideology or for clinical care by and for women, but as a business that was part of the medical industry and entitled to space on that playing field, the Tallahassee Feminist Women's Health Center achieved a precedent for the legal and economic legitimacy for all feminist women's health providers.

Chapter Two, "Divided Loyalties," looks at the fraught, emotionally tumultuous, and never truly coherent Mari Spehar Health Education Project, which was created by feminist-identified women in and around the Ozark mountain university town of Fayetteville, Arkansas. The Fayetteville feminist community, perhaps uniquely, involved an unusual spectrum of women: university students, members of Fayetteville's sizeable counterculture community, and women, including many lesbians, involved in the area's back-to-the-land movement, with some women drifting amongst and between these groups at various times. Galvanized at least temporarily by the Dalkon Shield-related death of Mari Spehar, a popular and charismatic member of the local feminist

community, Fayetteville feminists sought to convert a casual feminist health community group into some version of a feminist women's health project. The Mari Spehar Health Education Project, however, never truly achieved coherence, its direction compromised by the multiple loyalties of activist women in a small and physically isolated area and the politically diffuse nature of their feminisms. Although the Fayetteville feminist community sustained some sort of feminist health effort for the better part of a decade, its activities and its fortunes waxed and waned with the communities resources and capabilities. Given the overall rurality of the southeastern United States, it is instructive to consider the Mari Spehar Health Education Project as one illustration of the possible effects of rurality on feminist health organizing, and thus one component of understanding why feminist health organizations in the south developed where and how they did.

Chapter Three, entitled "She Did It Her Way," provides an encounter with an anomalous origin story that could not be more different than that of the Mari Spehar Health Education Project. The Memphis Center for Reproductive Health had a solitary, fiercely independent founder, Priscilla Chism, who was well connected, well trained, and exceptionally well versed in maneuvering among Memphis' political, medical, and social elites as well as in organizations like the Tennessee chapter of the National Women's Political Caucus and the Memphis chapter of the National Organization for Women. Ambitious and driven, Chism created the MCRH initially in 1974 as a for-profit organization. Two years later, however, MCRH had become a non-profit organization and Chism had abandoned ship, leaving the MCRH in the hands of loyal—and overtly feminist—staff. This dramatic and unusual origin story reveals that despite the commonness of the collectivist feminist model most commonly described in the historical literature, a feminist women's health organization might indeed spring from capitalist, elitist, and professionalized roots devoid of a sense of feminist community, and that this in turn might have connections to traditions of white southern women's community activism.

With Chapter Four, "Sisterhood, Self-Help, and Strife," we go from an anomalous origin story to a story of a revolutionary conception of what "feminist women's health" might be. The visionaries of the Atlanta-based National Black Women's Health Project pioneered an entirely new wholistic approach to health, centered in addressing individual and inherited trauma in an environment of intensive mutual support, designed specifically by and for Black women. The nurturing environment of Atlanta, the "Black Mecca," and its large communities of progressive, liberal, and feminist women of color, gave the NBWHP fertile soil in which to grow and develop. Yet the difficulty of the organization's work, the divergences in priorities of the NBWHP's two most central thinkers, and the administrative and financial precarity of the organization ultimately brought an end to the NBWHP's experiment in innovating a model of feminist health self-help expressly for Black women.

Unlike the National Black Women's Health Project and many other feminist health organizations, the subject of Chapter Five, the Atlanta Feminist Women's Health Center, successfully navigated the steep learning curve—and ideological adjustments—necessary to survive as an organization at a moment of intensifying political opposition to feminism and to reproductive autonomy. This chapter, entitled "Business as Usual," follows what appears to be an unremarkable adaptive journey on the part of the organization in order to demonstrate the ways in which it *was* remarkable. In particular, the ways in which changing political climates both within the feminist movement and outside of it necessitated that the Health Center negotiate certain modes of retreat or disengagement from long-held feminist ideologies concerning professionalization, economics, social change, and relationships with the state leads to a consideration that feminist health organizations not only had different forms and operated in different realms of service, but could also have differing organizational goals that might shift over time.

Not only did feminist women's health organizations exist across the south, in other words, but they existed in a remarkable variety that only serves to highlight the importance of filling in the southern gap in the feminist health historiography. While southern organizations often shared a great deal with non-southern feminist health organizations including organizational frameworks and philosophies, political goals, and types of medical and health interventions attempted, they also ranged well beyond. As reformers and revolutionaries, ideologues and public health footsoldiers, southern feminist health activists and their organizations were constantly in dialogue with their regions and localities, acutely aware that conditions on the ground would make the difference between thriving and disappearing.

This is perhaps true of all feminist health activists everywhere; research has so far not revealed any magical locale where feminist health organizations succeeded without struggle or interference. Yet there are ways in which, at least within the five organizations surveyed in this project, we see quite particular and distinct forms of negotiation between the people seeking to create feminist health alternatives and their local surroundings, whether in the deployment of connections and capitalism, the devising of a canny legal response, the reorganizing of scarce resources, the calculated relinquishing of radicalisms, or the bold reassessment of what health might mean if it were grounded in both raced and gendered life experience. The sample size is, naturally, far too small to enable sweeping claims about whether or not southernness specifically or generally engenders such diversity. The likelihood, after all, is that it does not. All organizations must respond to the distinctive potentials and pressures of the places in which they are located; as Tip O'Neill so famously said, all politics is local.

What this project does, I hope, suggest is that historians of feminist health have a responsibility to look for the ways in which these organizations' narratives are not amenable to our presuppositions, whether about feminism or about organizational dynamics or indeed about what

"women's health" is supposed to look like. The southern cases discussed here suggest nothing so much as that the extant traditional, more northern and coastally-focused historiography may be a bit too susceptible to its own self-descriptions and ideological narratives: if these southern examples are weird in their various ways, which they are, and southernness doesn't necessarily always explain why, which it does not, then the logical conclusion is that we are missing some weirdness, some wildness, some unexpected divergences and perhaps even some instructively disreputable variations on the feminist health movement elsewhere, too. In the name of gaining a fuller picture on the history of American feminism, to say nothing of the ingenuity and adaptiveness of American feminists, we owe it to ourselves and to subsequent generations to find it, lift it up, and allow it to illuminate still more untapped feminist possibility.

Chapter One

Feminists vs. Doctors:

Feminist Health and the Politics of Professional Regulation in *Feminist Women's Health Center, Inc. vs. Mohammad et al.*

Who has the right to provide medical services to women, and who has the right to play gatekeeper with regard to providers? These questions are at the core of a little-known but noteworthy anti-trust case, *Feminist Women's Health Center Inc. v. Mahmood Mohammad et al.* [415 F.Supp. 1258, N.D.Fla., June 09 1976; 586 F.2d 530, 1978]. This case, which argues strongly for the importance of examining feminist health activism in the U.S. south, was brought by the women of the Tallahassee, Florida, Feminist Women's Health Center against a group of physicians who were in the employ of what was then the only hospital in Florida's state capitol or its surrounding county. *Feminist v. Mohammad* charged five doctors who worked for the obstetrics and gynecology department of Tallahassee Memorial Hospital with violation of the Sherman Anti-Trust Act in the form of conspiracy to inhibit interstate trade. It was ultimately decided in favor of the Feminist Women's Health Center by the Fifth Circuit Court of Appeals, and injunctive relief as well as financial settlement was made to the Health Center.

In the larger picture of the sociopolitical history of American medicine, *Feminist v. Mohammad* is relevant in three intersecting ways and at three interlocking levels. As a matter of local medical authority and of the cultural viability of feminist health provision, *Feminist v. Mohammad* was simultaneously a symbolic and a practical affirmation of the 1970s feminist health movement and its nontraditional, often largely deprofessionalized, modes of working. At the level of federal law, this

suit—the first such lawsuit known to have been lodged by a feminist women's health clinic—has particular resonance for the history of the feminist health movement and other politically-aligned health providers (e.g. lesbian and gay clinics) in terms of the legitimacy it established for such nontraditional health care provision at the level of federal jurisprudence. Indeed, Betty Owen Stinson, the lead attorney for the plaintiffs, developed the case as an anti-trust suit because of her belief that the choice to file a federal suit was the only way it would be heard on its merits rather than being heard by a court of "prejudiced, ignorant men" in the "deep south" as a referendum on the organization's feminist politics and abortion services.[1] Finally, and equally meaningfully, the case fits into a larger mid-1970s national picture of efforts to deregulate professional authority within the learned professions, opening a space in which the traditional privilege of male-dominated associational power networks among physicians, lawyers, and the like could be weakened and democratized.

Background

The Tallahassee Feminist Women's Health Center formally began operations as a health care provider to the public in 1974. A core group of women based in Jacksonville had been meeting for some time, exploring, discussing, and consciousness-raising about the newfound realm of feminist health. Roe v. Wade was a watershed for these health feminists, as it was for many similar groups across the country. With its passage they determined to attempt to open a public health clinic that operated on feminist principles and offered a range of women's reproductive and sexual health services including abortion. In 1973 FWHC founding mother Linda Curtis went to Los Angeles, where she spent several months working and learning at what was then the "mothership" of the

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[1] Betty Owen Stinson interviewed by Hanne Blank, 1 November 2016. "I knew we would have no chance in [Tallahassee] local court. Idiots… all those prejudiced ignorant men. So I said we should bring it as an antitrust suit under the Sherman Antitrust Act, in Federal court."

feminist clinic movement, the Los Angeles Feminist Women's Health Center (LAFWHC), which was headed by feminist health movement pioneer Carol Downer.

This form of knowledge sharing and hands-on training was fast becoming a tradition within feminist health, and helped to establish the networks of social and political solidarity on which the movement depended as well as educating individual health feminists in the nitty-gritty of clinic operations. Clinics founded in relationship to the LAFWHC often adopted the "Feminist Women's Health Center" name, as in the case of the Atlanta Feminist Women's Health Center and the Tallahassee Feminist Women's Health Center, but it is important to note that they were not franchises, and were instead owned and operated solely by the women who founded and ran them in their given locales. The networks of relationships, however, remained vital: by 1975 there were enough such Feminist Women's Health Centers that they formed the Federation of Feminist Women's Health Centers, a network of member clinics maintaining close communications and routinely turning to one another for support, financial aid, staffing help, and educational resources and training. Many other feminist women's health clinics existed as well, but not all were founded on the same model or participated in the Federation. It is relevant to note that although the Tallahassee FWHC certainly partook in the group identities of women's liberation, of feminist health, and of the Federation of Women's Health Centers, there was nothing in those identities that approached or approximated the professional consolidation of power and control of groups such as the American Medical Association or the American College of Obstetricians and Gynecologists. This is true despite the degree to which "federation" sounds much grander than "decentralized network of a few hundred activists trying to make the best of it by sharing their limited resources." This will, as we shall see, become relevant.

Upon Curtis' return, the group decided that although they had originally hoped to open their center in the larger nearby city of Jacksonville, there was a bigger need for low-cost abortions,

including abortion providers who would accept Medicaid payment, in Tallahassee.[2] After locating a suitable venue, acquiring equipment, training its lay healthworkers, and contracting on a part-time basis with two local obstetrician-gynecologists to provide services such as writing contraceptives prescriptions and performing abortions that the state mandated had to be provided by those with medical credentials, they opened their doors in June 1974. For the first year of their operations, there appears to have been no significant friction between the feminists and the local medical establishment. Mahmood Mohammad, chief of the Obstetrics and Gynecology staff at the county's only hospital, Tallahassee Memorial Hospital (TMH), had in fact met with FWHC directors before the clinic opened, though he refused to work with them after they refused to meet his request to be paid $100 per abortion when the going rate was $25-35 per procedure. Mohammad had walked away from negotiations without any apparent ill will, however, and the FWHC made arrangements with another TMH-affiliated ob/gyn.[3]

All, in short, appeared to be going smoothly for the Feminist Women's Health Center. But then, having taken note of the new alternative medical establishment in town, the Tallahassee *Democrat* ran a public interest piece on the Feminist Women's Health Center on June 20, 1975. Providing a brief rundown of the FWHC's philosophies, services, and woman-centric approach, the story had been written primarily to document the fact that the feminist clinic had been sufficiently successful in its first year to necessitate bigger quarters, and was already planning a move. Generally positive, if slightly skeptical about the notion of Self Help Clinics in which women learned to

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[2] Tallahassee Feminist Women's Health Center / Women's Choice Clinic, "(From Our Memory) Testimony of the FWHC Given at the Hearing for the Preliminary Injunction," photocopy of document circulated among women's health centers, dated May 14, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute for Advanced Study, Harvard University.

[3] Tallahassee Feminist Women's Health Center / Women's Choice Clinic, "(From Our Memory) Testimony of the FWHC Given at the Hearing for the Preliminary Injunction," photocopy of document circulated among women's health centers, dated May 14, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

examine their own genitals including the use of a speculum, the brief article noted that the cost of abortion at the FWHC's Women's Choice Clinic was considerably less, about $150, than the cost for the same procedure done at the hospital (again, the city and county had only one, Tallahassee Memorial), which ranged from $250 to $500 and up. It also mentioned that physicians were "paid well for a relatively short and simple procedure," receiving $35 per abortion. It also mentioned one of the FWHC's gynecologists, Dr. A.D. Brickler, by name, stating that he had "been particularly helpful to the women's health center from the start."[4] Unmentioned in the article, but relevant historically, were two other facts: first, at the time, the FWHC was the sole abortion provider in Tallahassee accepting Medicare payments, and second, Dr. Brickler was African-American, Tallahassee's white doctors having refused to work with the FWHC. [5] [6]

On June 21, the helpful Dr. Brickler quit without notice. By July 7, with FWHC business still robust, the other of the FWHC's physicians, Spurgeon McWilliams, also African American and a TMH affiliate, was likewise threatening to leave. Only much later, after the FWHC's lawyers subpoenaed copies of the TMH ob/gyn department staff meeting minutes, would the reasons for this become clear. The July 1 meeting of Tallahassee Memorial's ob/gyn service featured intense and excited discussion about the FWHC, the article in the *Democrat*, and what the physicians felt ought to be done about the presence of the feminist clinic that was clearly cutting into their business.[7]

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[4] Susan Lykes, "A New Site Shows Growth of Feminist Health Center," *Tallahassee Democrat*, June 20, 1975, n.p, photocopy circulated among feminist health centers. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

[5] Minutes, Meeting of the Obstetrics Gynecology Service, Tallahassee Memorial Hospital, August 5, 1975. Photocopy in the Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

[6] Stinson, interviewed by author, 1 November 2016. "The women hired two African American doctors… Then they got pressured by their colleagues their white colleagues not to do it [work at the FWHC]. The leverage was that the white doctors were the ones who ran the local hospital and they could control hospital privileges. So that was a way they could squeeze the black doctors out."

[7] Meeting minutes, Obstetrics-Gynecology Service, Tallahassee Memorial Hospital, July 1, 1975. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.8. Schlesinger Library, Harvard University.

Seeking some sort of arrangement that might help stop them losing their doctors, two directors from the FWHC arranged a meeting at the hospital with Dr. Mohammad. Notes from the FWHC's subsequent conference calls with one of their sister clinics, the Women's Community Health Center in Cambridge, Massachusetts, relate that at this meeting Mohammad demanded that the FWHC stop all advertising, cease holding Self Help Clinic events, and refrain from speaking to groups or the general public about abortion.[8] The FWHC representatives refused, realizing that to agree would be to voluntarily make their clinic invisible except by word of mouth and would also compromise, if not obliterate, their agenda of educating women about their own bodies and their health care.

Dr. Mohammad countered by offering the FWHC representatives an opportunity to have an emergency meeting with members of his staff two days later. When two directors for the FWHC showed up to that meeting, only Mohammad among all his staff was there, and neither party was willing to change its tune.[9] On August 9, 1975, the FWHC lost the services of its remaining contracted TMH physician, Spurgeon McWilliams. McWilliams left saying that he was under fire from his hospital colleagues and feared the possibility of losing his hospital privileges if he continued to work for the FWHC. Additionally, he raised the frightening specter that if he continued working for FWHC, his physician colleagues might punish him by deliberately ignoring a patient of his were one to be taken to the Tallahassee Memorial Hospital emergency room suffering post-abortion complications, and might even let a woman die.[10]

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[8] Tallahassee Feminist Women's Health Center, "*Feminist Women's Health Center, Inc. v. Mahmood Mohammad et al.* Timeline," N.D. (circa early 1976?). Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.
[9] Tallahassee Feminist Women's Health Center, "*Feminist Women's Health Center, Inc. v. Mahmood Mohammad et al.* Timeline," N.D. (circa early 1976?). Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.
[10] Ibid.

Thus began several months of escalating antagonism between the doctors of the Obstetrics and Gynecological Service of Tallahassee Memorial Hospital and the Tallahassee Feminist Women's Health Center. The FWHC was unable to find a local gynecologist who would consent to contract with them, since all were dependent on having hospital privileges at the sole hospital in the county. With uncanny timing, the FWHC also found itself under unusual scrutiny from the Florida State Board of Medical Examiners, and were justifiably nervous about the possibility of being prosecuted for practicing medicine without a license although they had taken pains to ensure they were not doing so according to the laws then on the books. The FWHC entered into a part-time contract with Walker Whaley, a young resident physician from Jacksonville. Whaley too soon bowed out of his contract, but not without informing the women of the FWHC that both he and his boss had been the recipients of "concerned colleague" communications from Tallahassee physicians advising them both to have nothing to do with a clinic run by a bunch of "little girls."[11]

Suspecting they were on the receiving end of a concerted campaign to drive them out of business, the women of the FWHC decided to fight back, and began to speak to local lawyer Betty Owen Stinson about a possible legal strategy. Shortly, another local lawyer, Kent Spriggs, joined these discussions, forming a legal team to represent the FWHC. On Stinson's advice, it was decided that it would be better to seek redress through a federal anti-trust suit than through attempting to get a fair hearing in local courts whose judges, Stinson and Spriggs felt, were too socially and politically conservative, too parochial in their thinking, and too embedded in the social hierarchies of locally powerful white professional men to hear the case on its merits.[12] On October 1, 1975, the Tallahassee Feminist Women's Health Center filed suit in U.S. Federal District court against six local

[11] Women's Community Health Center, Telephone Meeting Notes on call with Tallahassee FWHC, December 16, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.
[12] Stinson interviewed by author, 1 November 2016.

physicians and a member of the Board of Medical Examiners, charging conspiracy to restrain trade and create a monopoly in violation of the Sherman Antitrust Act.[13] The case would be dismissed, in December of 1976, a mere twelve hours before it was to be heard. It would later be appealed to the Fifth Circuit Court of Appeals in New Orleans to be heard by Judges Homer Thornberry and Alvin Rubin. Ultimately, an out-of-court settlement in the Fifth Circuit Court of Appeals would vindicate the Tallahassee Feminist Women's Health Center in January 1980.

Deeper Background on *Feminist v. Mohammad*

A deeper understanding of the background and actions leading up to the case help us to understand the larger significance of Feminist v. Mohammad. Although the case was formulated and argued on the basis of antitrust law, this choice was both strategic and somewhat odd. The case was ultimately argued and won on the basis of this essentially economic claim, but far more than mere economics lay behind the actions of both doctors and feminists. Deeper detail of the events of the case, revealed via testimony and deposition, reveals a complex and interlocking set of conflicts that ranged far more broadly than business or profits, but involved issues of medical professionalization, the power and reach of professional associations, sex and gender roles, the politics of medical access for underserved groups, and, last but not least, local and regional dynamics of customary power.

After the *Democrat* article about the FWHC appeared, the physicians of Tallahassee Memorial Hospital (TMH) convened a staff meeting. The minutes of the July 1, 1975 Ob-Gyn Service staff meeting relate physicians responding to this newly public threat to their authority in professionally predictable ways. One or two of the physicians expressed concern about specific issues of practice

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[13] Tallahassee Feminist Women's Health Center, Press Release, October 1, 1975. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library , Harvard University. See also *Feminist Women's Health Center Inc. v. Mohammad,* 415 F.Supp. 1258, N.D.Fla., June 09 1976 and 586 F.2d 530, 1978.

that might or might not have been taking place at the FWHC. Dr. Brickler, the FWHC's former employee, specifically expressed concern about what the effect on patient welfare might be if the feminists employed a physician from out of town, and thus, given that TMH was the only hospital in Leon County, one who would not already have hospital privileges at TMH and thus be unable to transfer a woman with post-abortion complications directly into inpatient care.[14]

The remainder of the physicians, however, did not seem invested in questions of patient care, or willing to consider what sort of relationship the TMH and its doctors might forge with the FWHC for the sake of patient welfare. The physicians made no attempt to open dialogue or to visit the FWHC, to inquire about its policies, practices, or staffing, or otherwise treat the feminist health providers in any way as colleagues or potential colleagues. Instead, the physicians called immediately upon the power of professional associations and state power to attempt to intimidate the FWHC staff.

One doctor suggested that the situation be brought to the attention of the Capital Medical Society (CMS), the county-level affiliate of the Florida Medical Association, the state chapter of the American Medical Association. Another physician seconded this, adding that a letter be composed including specific items the doctors would ask the CMS to endorse in regard to the FWHC, thereby calling for not only an associational response to the threat posed by the FWHC but also for a unified response from physicians. Given that the TMH physicians had already unified amongst themselves against the FWHC, it is unsurprising that they sought to bring the rest of the region's doctors explicitly to their side.

[14] Tallahassee Memorial Hospital did have an emergency room, where anyone could seek care for any reason regardless of previous care relationship with a TMH physician. Using the emergency room became the customary arrangement for any necessary follow-on care for the FWHC's patients when they proved unable to contract with a physician who would have TMH hospital privileges.

A third doctor read a draft of a letter he had already taken the trouble to compose to the Florida State Board of Medical Examiners requesting their assistance, in making an especial point of investigating and interrogating the FWHC's activities to see whether any evidence might be found that could be used to discredit or close the FWHC. At that point, a fourth physician suggested that with these letters be included a copy of the recommendations for freestanding gynecological surgical clinics issued by the Florida Academy of Obstetricians and Gynecologists (a chapter of the national American College of Obstetricians and Gynecologists), recommendations which included stipulations about physician staffing, something the physicians had already taken care to ensure was locally impossible.

All of these motions were seconded and passed, and the decision was made to send letters not only to the groups already mentioned but also to the Leon County Health Department and the State Health Officer in Jacksonville, thus attempting to bring additional layers of state surveillance and control into play.[15] The Capitol Medical Society and the Florida Medical Association would both, after receiving these letters, formally affirm the complaints made by the Tallahassee doctors. These professional associations provided financial and social support to the TMH physicians throughout the trial. The Board of Medical Examiners also responded affirmatively, at least partially on the basis of personal ties between chief medical examiner George Walker and some of the TMH physicians.

The doctors would continue these kinds of actions both in their private staff meetings and in less-formal individual and collective actions over the next several months. Later in July Dr. Mohammad would write to the Ethics Committee of the Capital Medical Society under his own name, inquiring as to the professional ethics of offering free contraceptives advice to the public.

[15] Minutes, Monthly Meeting of the Obstetrics-Gynecology Service, Tuesday, July 1, 1975, Tallahassee Memorial Hospital. Photocopy in the Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

This was a clear attempt to procure a ruling with an official organizational imprimatur on activity that was one of the FWHCs primary health education services.[16] Additionally, in August, the doctors passed a staff-meeting resolution that "physicians in the Capital Medical Society should not be associated with agencies that advertise their services," in essence declaring a boycott of association with the FWHC on the part of local doctors.[17]

Unbeknownst to the Ob/Gyn staff as a whole, various of their number would continue to willingly associate with the FWHC for years to come. Various of the TMH's ob-gyns quietly contracted with the FWHC to act as strictly off-the-record emergency backup resources in the event of complications following abortions performed at the Women's Health Center.[18] After the lawsuit was filed, however, at least one of these doctors would, or so FWHC staffers later alleged, end up encouraging women whom he treated for complications to make depositions against the FWHC.[19]

Under-the-table arrangements of convenience aside, however, and by the clear light of professionally-organized day, the physicians affiliated with Tallahassee Memorial Hospital and the Capitol Medical Society felt it entirely appropriate to use their membership in a professional organization as a principle on which to establish an oppositional boycott to an independent clinic whose practitioners were not part of the same professional organization. This motif of the physicians' group arraying itself, via their access to professional and regulatory organizations, as the

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[16] Mahmood Mohammad to Ethics Committee, Capital Medical Society, July 10, 1975. Photocopy in the Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

[17] Minutes, Meeting of the Obstetrics Gynecology Service, Tallahassee Memorial Hospital, August 5, 1975. Photocopy in the Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

[18] Tallahassee Feminist Women's Health Center / Women's Choice Clinic, "(From Our Memory) Testimony of the FWHC Given at the Hearing for the Preliminary Injunction," photocopy of document circulated among women's health centers, dated May 14, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

[19] Women's Community Health Center, Telephone Meeting Notes involving FWHC and WCHC, December 16, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

authoritative official opposition to nonprofessionalized interlopers was carried forward in increasingly explicit ways after the TMH doctors announced their private boycott.

On August 29, acting in his capacity as chair of the Ob/Gyn Service, Mahmood Mohammad wrote to George Palmer, executive director of the State Board of Medical Examiners, copying the letter to Tom Wood, the sitting president of the Capital Medical Society and the CMS's Board of Governors. In it, Mahmood suggested the possibility that the FWHC, now without a local physician, could have been practicing medicine without a license, stating that "if there is a physician we do not believe he is a member of the medical staff of TMH."[20]

Notwithstanding the fact that the State Board of Medical Examiners was empowered only to regulate the licensing of physicians and matters pertaining to physician licensure (such as the practice of medicine without a license), Mohammad stated that the FWHC was "alleged" to be engaging in the "unethical" practice of advertising their services, and requested that Palmer "take appropriate corrective measures."[21] Mahmood added that the lack of a local physician at the FWHC might create continuity of care problems in event of post-surgical complication in the FWHC's abortion patients. This was a barely-veiled threat: on principle and under the law, any presenting patient in an emergency room has the right to treatment, regardless of whether they are under the care of a physician affiliated with the hospital in question. It would of course have been highly unethical for TMH doctors to refuse emergency care, or provide substandard care, to any emergency patient on such a basis. It is noteworthy that Mohammad felt no compunction in suggesting that such a thing might happen at TMH.

On September 10, Mohammad struck again, this time in a letter cosigned by seven members of his staff. The letter was sent to Dr. Robert Thompson, the head of the Ob-Gyn department at

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[20] Mahmood Mohammad to George Palmer, August 29, 1975. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.
[21] Ibid.

University Hospital in Jacksonville and Walker Whaley's residency supervisor. Mohammad did not attempt to invoke his own personal authority or insist that his colleague, Dr. Thompson, regulate the professional activities of his department or his staff to Dr. Mohammad's liking where FWHC was concerned. But he was not above invoking the authority of both the regional medical community or the American College of Obstetricians and Gynecologists. "This is the feeling of this Department that" Mohammad wrote, "participant residents from that program [University Hospital Jacksonville] are getting themselves into a type of situation which neither ACOG, nor physicians in this community, approve."[22]

Indeed, the young Dr. Whaley would also be directly discouraged from working for FWHC by George Palmer, Executive Director of the Florida Board of Medical Examiners [BOME] and the recipient of Mahmood's letter requesting the BOME's intervention in the situation. Palmer inspected the FWHC in early September, and acknowledged that there was nothing illegal about Whaley's medical service at the Women's Health Center or about the general practices followed at the FWHC. In a follow-up letter to Mohammad, who had requested his intervention into the goings-on at the FWHC, Palmer described this phone call to Whaley and finished by saying "The present set up, though legal, leaves much to be desired from the medical standpoint." But Palmer nevertheless took it upon himself to telephone Dr. Whaley to warn him off of working for the feminists. That he had come to the direct attention not just of the Board of Medical Examiners at large, but its executive director specifically, was not lost on Dr. Whaley, who appears to have tried to warn the directors of the FWHC that the local traditional medical establishment was gunning for

[22] Mahmood Mohammad to Robert Thompson, Department of Ob-Gyn, University Hospital, Jacksonville, September 10, 1975. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.10. Schlesinger Library, Harvard University.

them.[23] By that point, however, the feminists were well aware that this was the case, and were preparing to file suit.

Feminist v. Mohammad in Local and Movement Contexts

In hindsight, an anti-trust suit would seem perhaps the most unlikely of all strategies for an embattled feminist health clinic to take up. Health feminists were hardly business-focused, and were often self-admittedly poor businesswomen.[24] Politically, they tended toward a left-leaning critique of capitalism in which "the profit motive is pernicious," and many established themselves as nonprofit organizations either via establishing 501(3)(c) nonprofit tax exempt status with the IRS or via internal organizational agreement.[25] They often operated on the proverbial shoestring, and so to keep their overhead low as well as to embody the ethos of "people over profits," feminist clinics deployed economical equipment and labor strategies, purchasing used clinic equipment and using lay, rather than credentialed, healthworkers wherever possible.

Unlike the hospital and clinic settings of the mainstream medical industry, 1970s feminist health clinic administrators were not highly-paid career administrators, but instead members of the collectives that created the clinics in the first place. Both salaried administrators and hourly workers might be asked to give up part or all of their slender paychecks when earnings fell short. At the Atlanta Feminist Women's Health Center, for example, administrators did this for several years in the late 1970s and early 1980s without expectation of ever making up that income, although eventually, in the relatively financially flush year of 1985, three administrators were awarded long-

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[23] Women's Community Health Center, Telephone meeting notes with FWHC staffers, October 28, 1975. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.11. Schlesinger Library, Harvard University.

[24] Betsy Randall Davis interviewed by author, November 1, 2016. Randall Davis was the director of the Gainesville Women's Health Center from 1974-1978. "Our strength was not business. This was probably true of most women's health centers at the time."

[25] Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (New York: Praeger, 1978), 7.

overdue back salary.[26] A "Regular Staff Salary Agreement" included in the Atlanta clinic's 1978 personnel policies stipulated that workers would ideally be paid for 40 hours of work per week, but would be expected to volunteer an average of 20 additional hours weekly. Further, potential hires were asked to agree that "depending on the financial situation of the Health Center, it may be necessary to volunteer a larger portion, up to my entire time spent at the Feminist Women's Health Center."[27] Feminist clinics typically prioritized making care economically accessible to patients, deliberately setting fees for services at below-market rates when they could as well as accepting Medicare payments. Both of these economic features were part of the Tallahassee FWHC's standard practices. Clinics also frequently offered sliding fee scales where fees were indexed to patients' ability to pay. To say that it was uncharacteristic of 1970s health feminism for the Tallahassee FWHC to frame its dispute in the terms of federal anti-trust legislation, with its overt and concerted emphasis on the protection of trade and capitalist market competition, is an understatement.

The legal approach that was chosen represents, in many ways, an intentional elision of many of the fundamental issues at work in the case. All lawsuits are limited by the terms of the charges that have been filed. These terms place restrictions on the kinds of issues that may enter jurisprudential consideration, the types of evidence that can be presented (and which will be heard), and the types of redress that may be made available. Anti-trust suits are limited to depositions and deliberations concerning accusations of unlawful limitation of interstate trade.[28] If any social or political reasons behind such attempted or actual restraint of trade, such as e.g. the sexism, threats,

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[26] "Minutes of the Executive Committee Meeting," June 19, 1985. Unlabeled folder. Private collection, Atlanta Feminist Women's Health Center.
[27] "Regular Staff Salary Agreement," Folder "Administrative Files: Personnel," Box 20, Papers of the Atlanta Feminist Women's Health Center, Rubenstein Archive, Duke University.
[28] For an overview of what the Sherman and other U.S. antitrust laws specify, see U.S. Federal Trade Commission, "The Antitrust Laws" *Guide to Antitrust Laws*. https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws Accessed January 23, 2019.

or battles over professional authority entwined in *Feminist v. Mohammad*, are to be legally addressed, they must be addressed in a separate suit(s) of some other type(s).

An antitrust proceeding determines only one thing: whether a specific type of illegal trade action was or was not taken. The reasons behind such illegal trade actions may be salient, but legally speaking, they are inconsiderable. Looking simply at the legal record of this case, in other words, does not and indeed cannot illuminate most of the suit's salient background issues. For this reason, the legal record alone cannot illuminate the rationale on which the anti-trust strategy was chosen for *Feminist v. Mohammad*, nor can it illuminate the positive double effect achieved for the feminist health movement through one feminist health clinic's successful pursuit of an anti-trust lawsuit. The legal record does not even reflect the fact that for political reasons, it was strange for a feminist health clinic to find itself embroiled in an anti-trust suit.

Why, indeed, would a feminist clinic choose an anti-trust suit in a case like this one, as opposed to other options like a sex discrimination suit or perhaps a case based on threatened or actual medical negligence on the part of the physicians? In a November 2016 interview, the Honorable Betty Owen Stinson, at that time newly retired from the New York Supreme Court 12th Judicial District, recalled her thought process as she met with the women of the Tallahassee Feminist Women's Health Center to discuss legal options in 1976. At that time, Owen Stinson stated, she and other members of the legal team felt that the composition of local Tallahassee courts was such that the case would have "no chance in local court, none at all."[29] The local court judges, she felt, were "a bunch of idiots on the bench, prejudiced ignorant men, so I said we should bring it as a Sherman Anti-Trust suit and take it into the Federal courts instead."[30] Owen Stinson, her fellow attorneys, and the FWHC all agreed that local judges were likely to be prejudiced in favor of the

[29] Stinson interviewed by author, 1 November 2016.
[30] Ibid.

local doctors, Board of Medical Examiners members, and others in positions of power in the local medical establishment who were implicated in the case, and biased *against* the feminists of the FWHC, whom they would likely view as a threat to established and legitimate power structures both locally and politically.

There is no legitimate historical argument to be made that such prejudices in favor of established power structures and against social reform politics are distinctively Southern. Members of the learned professions have leaned on and exploit their associational power and social status all over the country, and surely opposition to women's liberation politics has never been limited to any particular geographical location. The papers of the Women's Community Health Center in Cambridge, Massachusetts contain a document circulated amongst feminist health clinics which was, based on textual references, compiled during the period in which *Feminist v. Mohammad* was in the appeals process, describing circumstances of organized police and other "harassment of women's centers" in both Tallahassee and in Los Angeles.[31] Demonstrably, health feminists understood that establishment resistance to their presence and practices was not a regional specialty but a phenomenon that could happen anywhere, even in "liberal" southern California. Clinic workers nationwide were clearly intended to learn from the Tallahassee and Los Angeles examples.

It is nevertheless relevant to a historical consideration of this specific case that both the feminists of the FWHC and Owen Stinson felt, at the time of the case, that the power dynamics of the situation in Tallahassee reflected traits they were willing to identify as Southern, including cronyism, social conservatism, and participation in a long legacy of willingness to exploit and control the disadvantaged. Owen Stinson, herself an Alabaman who attended Clemson as an undergraduate, referred to her opponents in this case sarcastically as "good ol' boys" and less facetiously as "typical

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[31] "Harassment of Women's Centers," Records of the Women's Community Health Center, Cambridge, MA, 1963-1987, Box 1a, Schlesinger Library, Harvard University.

Southern men at that time… sons of bitches."[32] While it is true that white cisgender heteronormative male power was and still is a national constant, and that cronyism and social conservatism know no geographical boundaries, it is also true that these characteristics, and an overt social willingness to accept them as culturally foundational has long been associated with the South both in the cultural vernacular and by historians. Bertram Wyatt-Brown was perhaps the first to promote the idea of a South unified by a socially conservative white male "honor culture," but the overt white male paternalism of the slavery system and of Jim Crow society has also been the subject of substantial historical analysis.[33] It is possible, and I argue historically legitimate, to say that while white supremacist patriarchy is a constant of U.S. culture, its cultural presence and role in different regional cultural vernaculars may either differ somewhat in nature, in effect, in reputation, or some combination of these things. Certainly numerous historical actors speak of Southern white masculinity as being in some ways distinctive in their experience. Since these subjective experiences helped to shape their actions, it seems incumbent on the historian to at least entertain the possibility that a phenomenon of a distinctively Southern white masculinity, however socially constructed it might be or have been, was a subjective reality.

Linda Curtis, one of the founding mothers of the FWHC, was for example quite explicit about the specific linkages she perceived between Southernness, masculinity, whiteness, and the behaviors of the Tallahassee physicians while also retaining an awareness that the patriarchy writ large oppressed women everywhere. In April 1976, early in the progress of *Feminist v. Mohammad*,

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[32] Ibid.

[33] Bertram Wyatt-Brown, *Southern Honor: Ethics and Behavior in the Old South* (New York: Oxford University Press, 1982); see also Craig Thompson Friend and Lorri Glover, eds., *Southern Manhood: Perspectives on Masculinity in the Old South* (Athens: University of Georgia Press, 2004); Glenda E. Gilmore, *Gender and Jim Crow: Women and the Politics of White Supremacy in North Carolina, 1896-1920* (Chapel Hill: University of North Carolina Press, 1996); Kenneth Greenberg, *Masters and Statesmen: The Political Culture of American Slavery* (Baltimore: Johns Hopkins University Press, 1985); Stephanie McCurry, *Masters of Small Worlds: Yeoman Households, Gender Relations, and the Political Culture of the Antebellum South Carolina Low Country* (New York: Oxford University Press, 1995); Nancy MacLean, *Behind the Mask of Chivalry: The Making of the Second Ku Klux Klan* (New York: Oxford University Press, 1994); Trent Watts, ed., *White Masculinity in the Recent South* (Baton Rouge: Louisiana State University Press, 2008).

Curtis gave a speech entitled "The Tallahassee M.D. Conspiracy" at the first Southeastern Women's Health Conference, a regionally-focused conference for health feminists that was convened in Gainesville on the campus of the University of Florida. Curtis did acknowledge that other women's health organizations were "under attack" in other parts of the country as well and that the power structures of the American Medical Association and the American College of Obstetricians and Gynecologists represented a potential obstacle to health feminism nationally. Yet she was also unequivocal about what she perceived to be connections between perceptions of Southern inferiority and mistreatment of feminists by others in the feminist community and in the wider world, about the South as "colonized" by white supremacist interests, and about an unbroken Southern legacy of white male capitalist exploitation and oppression that Curtis described as stretching from the antebellum era to the present. Curtis painted this picture in order to suggest that the Tallahassee FWHC's problems were but one manifestation of it.[34]

> "White male supremacists control the South's industry. This spills over and pollutes every other aspect of our economy including health care delivery. It is no coincidence that the South is the bastion of the AMA monopoly! Tallahassee's health system is a microcosm of the pervasive system of control that the AMA now has on this country's health system. ...In Tallahassee, Blacks have had to fight to get on staff at the only hospital in the county, Tallahassee Memorial Hospital. Unionization at TMH has failed due to the very tight control of workers that exists in the South. Individuals who have tried to set up clinics have not been able to succeed. A few years ago some of the same MDs that we're suing managed to close down the Public Health Department's pre-natal clinic. …Women in Tallahassee…have resorted to giving birth without any assistance. They have been driven to using the TMH emergency room like an outpatient clinic and seek out the FWHC's services as a welcome improvement over previously existing conditions."[35]

It is, therefore, reasonable to say that at least in the eyes of the feminists and attorneys who filed suit, the choice to translate the problems faced by the Tallahassee FWHC into the language of

[34] Linda Curtis, "The Tallahassee MD Conspiracy" lecture given at the First Southeastern Women's Health Conference, Gainesville, FL, April 3 1976. Papers of the Women's Community Health Center (Cambridge, MA), Box 15a, The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute, Harvard University.
[35] Ibid., 4.

anti-trust law was a way of placing their case beyond the reach of what they perceived as the pernicious and inherently biased reach of Southernness. The choice to constitute the case as being primarily about trade rather than primarily about gender bias or associational politics removed the most socially contentious issues from consideration, therefore making it inherently less likely that the case would be heard as a referendum on feminism or women's reproductive health care or abortion or even merely an attack on traditional male-dominant, white-dominant power structures. It also, simultaneously and not coincidentally, took the case out of the jurisdictional reach of the local judges who were felt to be too ignorant and prejudiced to interpret the law in an unbiased fashion and instead frame it as a matter for a literally higher jurisprudential power.

This may be viewed as part of a larger and broader 1960s and 1970s pattern of identity-political causes turning to federal authority for assistance and relief of oppressive conditions that were too much a matter of structural inequity to be adequately addressed through local injunctions. The Civil Rights movement may be seen as the locus classicus of the strategy, with its long record of Supreme Court cases and federal legislation establishing and defending a variety of civil liberties at the federal (and Constitutional) level. *Brown v. Board* (1954), *Hernandez v. Texas* (1954), *Cooper v. Aaron* (1958), *Patterson v. Bailey* (1962), and of course *Loving v. Virginia* (1967) all reflect this type of use of federal authority to supersede and disallow local or state defenses of structural inequality and oppression. The same is true of *Atlanta Motel Inc. v. U.S.* and *Katzenbach v. McClung* (both 1964), which parlayed local cases into defenses of the constitutionality of the 1964 Civil Rights Act.

The feminist health movement had also already partaken of a version of this strategy. Rather than looking to the federal government for a higher authority on the law on behalf of people of color, however, feminist health activists had looked to it to impose its regulatory authority on the medical and pharmaceutical industries on behalf of women. The Nelson hearings of 1970 took place after Sen. Gaylord Nelson (D-WI) became aware of feminist journalist and women's health

activist Barbara Seaman's book *The Doctor's Case Against the Pill*, an exposé of the health risks and side effects of combined oral contraceptive pills. [36] Nelson organized a Senate hearing on the issue at which feminists mounted a successful protest to have women's voices heard on the problems of how and whether women were notified by their paternalistic physicians of the potential risks of the Pill. The upshot of the Nelson hearings was a 1970 Food and Drug Administration ruling requiring that manufacturers add printed patient information inserts describing potential risks and side effects to the packaging for contraceptive pills [33 Federal Regulations 9001].[37] This federal solution represented a bypass of the potentially sexist or paternalist attitudes of individual physicians, the willingness of professional associations to recommend that physicians disclose risks to women, and the readiness of individual states to require that physicians disclose pharmaceutical risks to patients.

Leveraging local or individual happenings into broader political context for wider effect is the essence of grassroots activism. It is unsurprising, in historical context, that this strategy appealed to the Tallahassee Feminist Women's Health Center and its legal team. It is simultaneously relevant that the TFWHC and its lawyers viewed the federal suit as a means of avoiding local, and specifically Southern, sociopolitical pitfalls. Some legal strategies kill two birds with one stone, and *Feminist v. Mohammad* is an excellent example.

By choosing an anti-trust strategy, the FWHC and its lawyers made a bid that feminist health clinics, with their unorthodox clinical and business practices, be recognized as legitimate business entities at the federal level, their economic interests as worthy of the protection of the nation-state as those of more conventionally constituted medical businesses. While certainly health feminists did not typically view their clinics primarily as businesses—they tended to prioritize other roles like

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[36] Two American histories of oral contraception that discuss the Nelson Hearings are Elaine Tyler May, *America and The Pill: A History of Promise, Peril, and Liberation* (New York: Basic Books, 2010) and Elizabeth Siegel Watkins, *On The Pill: A Social History of Oral Contraceptives, 1950-1970* (Baltimore: Johns Hopkins University Press, 1998).

[37] This legislation has been regularly revised and expanded, with the most recent revision in April 2014. It is currently codified in Code of Federal Regulations Title 21, Volume 4 (21CFR201.57).

education, healthcare, creating community resources, political change-making—health feminists involved in clinic creation necessarily had dealings with state boards of medical examiners, heath facility inspectors, professional licensing boards, business licensing bureaus, and the like in order to legally serve the public. They understood that formal governmental recognition of a business entity is both socially meaningful and legally legitimizing. They also understood, as reflected in the many letters, press releases, and case updates that were circulated among feminist women's health clinics during the case's litigation, that the potentially legitimizing outcome of the case had meaning for the feminist health movement writ large, not just for the Tallahassee clinic.[38]

Victory for the FWHC in *Feminist v. Mohammad* had, in short, broader ramifications than just financial or injunctive relief for Tallahassee's health feminists. Acknowledgment on the part of the federal courts that the Tallahassee FWHC had a legitimate interstate trade presence, that its ability to conduct trade had been illegally compromised through concerted efforts on the part of the Tallahassee Memorial Hospital physicians, and that there was no valid reason that any barrier to the FWHC's business should exist was a *de facto* acknowledgement that health care provision need not take the forms of the traditional medical establishment to be recognized as legitimate. This, given the opposition of traditional medical practitioners and institutions both in Tallahassee and elsewhere, was meaningful, not least in the ways in which it signaled that the old boys' networks of medicine, and particularly the American Medical Association, were beginning to lose some of their historically ironlike grip on the provision of medical services and the control of medical industry in

[38] To date I have found press releases, newsletters, correspondence, notes from telephone conference calls, and newspaper clippings regarding the Tallahassee FWHC's lawsuit and its progress in the papers of every feminist health organization I have researched, including the National Black Women's Health Project, the National Women's Health Network, The Women's' Community Health Center (Cambridge MA), the Gainesville Women's Health Center, the Atlanta Feminist Women's Health Center, the Los Angeles Feminist Women's Health Center, the New Hampshire Women's Health Center, the Emma Goldman Clinic (Iowa City, IA), the Tampa Women's Health Center, and the Mari Spehar Health Project (Fayetteville, AR). The reach of these materials and the fact that they were saved testifies not only to the extended networks of communication among health feminists but also to the concern with which this trial and its outcome were regarded.

the United States. This too, it turns out, was part of a significant larger picture in the American political and social landscape.

Feminist v. Mohammad **and the Deregulationist Moment**

The American Medical Association (AMA) had long been one of the nation's most powerful professional organizations, with a crushingly strong lobbying arm. Founded in 1847 in an attempt to organize formally trained physicians in the face of a notably disorganized and variably trained population of medical practitioners, the AMA had historically fought to maintain internal control of physician activities in the United States while keeping state and federal interference and regulation of physicians to a minimum. At this the AMA was very successful, for instance in their successful shutting down of President Franklin D. Roosevelt's New Deal efforts to create compulsory national health care, which the AMA argued would have unjustly removed physicians' ability to maintain necessary medical autonomy in the form of direct fee-for-service patient relationships. Through a combination of canny lobbying, the establishment of physician-run health insurance bodies such as Blue Cross / Blue Shield, and a complex array of social controls over the practice of medicine that included imposing strict limits on the numbers of doctors graduating medical school each year, the AMA, as Paul Starr put it, "channeled the development of hospitals, health insurance, and other medical institutions into forms that did not intrude on their autonomy."[39] By presenting itself strictly as a professional organization that did not conduct business but was a mere umbrella organization comprised of state and regional chapters whose individual doctors were the ones dealing in trade, the AMA was able to argue that it was not a "corporation." Thus, even as it became what historian Elliot A. Krause characterizes as "a veto group" in Congressional politics, the AMA was able to

[39] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 420.

maintain exemption from many kinds of government investigation or regulation, including under the Sherman Antitrust Act.[40]

The AMA reached its peak of influence just after the Second World War, but shortly thereafter began to find itself losing both popularity and political ground. AMA controls on medical school graduation rates, for example, had led to a physician-to-population ratio that was basically unchanged—approximately 130 physicians per 100,000 population—from 1931 to 1961, despite massive post-war increases in population and increasing specialization among physicians. Physician shortages, particularly in rural or impoverished areas, were common, and not a few of the new hospitals built with funding from the Hospital Survey and Construction Act (the Hill-Burton Act) of 1946, intended to achieve 4.5 available hospital beds per 1000 U.S. population, had initial difficulties achieving full staffs.[41] As the refusal on the part of organized medicine to voluntarily constitute itself so as to provide care to the rural and the poor became increasingly evident and suburbanization led to increasing income stratification that made the absence of low-income health care access ever more apparent, the government decided to step in.

The Johnson administration's "Great Society" vision named health care as a major front of its "War on Poverty." The Johnson administration not only saw to the passage of Kennedy administration legacy projects like Medicare-Medicaid and the Community Mental Health Centers Act of 1963, but went further, enacting the Economic Opportunity Act of 1964 and the Office of Economic Opportunity Neighborhood Health Center program. Taken together, this body of legislation asserted a level of state intervention into medical activity that had never before been seen in America. Not only did the government insist upon health care accessibility for the poor and

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[40] Elliot A. Krause, Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present (New Haven: Yale University Press, 1996), 37.

[41] Krause, 38-39; Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1999), 216-227.

underserved, but it did so through programs that refused doctors the right to set their own fees and to engage in their customary direct fee-for-service transactions with individual patients while simultaneously deprofessionalizing the structure, location, and dispensing of care by mandating the inclusion of nonphysician community members in its programs. A great deal of activity physicians were accustomed to self-regulating for their own needs and benefits was summarily taken away from them, at least within the scope of these particular programs.[42]

The writing was on the wall for the AMA: status as a professional organization no longer made it immune from all federal regulation. Nor would it, going forward, necessarily be able to behave in the manner to which it had become accustomed.[43] It is not, in fact, mere coincidence that very shortly after the Tallahassee Feminist Women's Health Center chose to appeal the initial dismissal of their case, the Federal Trade Commission chose to go after the AMA itself on anti-trust grounds. *FTC vs. AMA* would not be decided until 1982, but when the Supreme Court issued its decision, the decision was made in favor of the Federal Trade Commission, ruling that public interest in market competition was greater than the public interest in allowing professional groups to place ethical restrictions on the commercial activities of their members. This decision rested on scaffolding provided by *Goldfarb v. Virginia State Bar* (1975), which ruled that the Bar Association members engaged in business as individuals, and therefore the fact that they had a professional association did not exempt them from anti-trust litigation. *Goldfarb* had been the crack in the wall; *FTC v. AMA* effectively destroyed the "learned professions" exemption that had for so long immunized the AMA from anti-trust prosecutions.

Historian Carl Ameringer describes this late-70s moment as one when "consumer advocates on from the left converged with free-market economists from the right to isolate the medical

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[42] Krause, 42-44; Starr, 369-373.
[43] Carl F. Ameringer, "Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association," *Journal of Policy History* 12 no 4 (2000): 445-453.

profession both politically and ideologically."[44] In *Feminist v. Mohammad,* we see this happening both in the larger political way, in the form of an anti-trust suit filed by a small independent politically left-wing feminist health clinic against the high-status male employees of a powerful local medical institution, and in a specific ideological way having to do with the pointed judicial denial of one of the defendants' attempted legal defenses.

The defense in question was the Noerr-Pennington doctrine, a legacy of two 1960s U.S. Supreme Court cases, *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.* (1969) and *United Mine Workers v. Pennington* (1965). In essence, the doctrine legally exempts a defendant's attempts to petition or influence public officials or public regulatory bodies from being considered as evidence against said defendants in anti-trust cases, even if the effect of the petition or influence was to help to eliminate competition in ways that benefited the defendant.[45] For example, if as in *Noerr*, defendant railroads campaigned for legislation that would have ruinous effects on the trucking industry but permit the railroads to continue operating normally, the defendant's campaigning for that legislation could not be counted as evidence that they were attempting to conspire to restrict trade. The right of petition would be considered political activity and not business activity and would therefore, as political activity, be protected by the Bill of Rights.

The Noerr-Pennington doctrine is, however, only a doctrine, a principle by which laws are interpreted and cases argued; it is not a law. Judges recognize that not all petitioning of public officials or regulatory bodies is alike, not all such officials or regulatory bodies are the same, and that petitioning does not affect all cases identically. Thus the doctrine's scope and applicability are open to debate and interpretation. The Federal Trade Commission's 2006 report *Enforcement Perspectives on the Noerr-Pennington Doctrine* runs to 41 pages; further updates to Noerr-Pennington entered the legal

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[44] Ibid., 446.

[45] Federal Trade Commission, *Enforcement Perspectives on the Noerr-Pennington Doctrine*. Federal Trade Commission Staff Report (2006), pages 6-12.

literature in 2011. At the time of *Feminist v. Mohammad*, in other words, Noerr-Pennington was not set in stone, and it remains open to interpretation.[46]

In *Feminist v. Mohammad,* the physician defendants attempted to invoke Noerr-Pennington in their own defense by claiming that their efforts to petition several different professional associations should be exempted from anti-trust consideration. However, of the bodies the physicians attempted to petition only one, the Florida Board of Medical Examiners, was actually a public regulatory body. But the defendants attempted to claim that petitions to the Capitol Medical Society and the Florida Medical Association (the county and state chapters, respectively, of the American Medical Association) and the Florida chapter of the American College of Obstetricians and Gynecologists ought also to be exempted under Noerr-Pennington by arguing that the regulatory functions of the AMA and ACOG made them "quasi-governmental." It was this principle, glossed in the judicial opinion as indicating that professional organizations of doctors served a "quasi-governmental" regulatory function, to which Federal Judge William Stafford appealed both when he dismissed the original case one day before it was to be heard in December 1976 and in his February 23, 1977, denial of the FWHC's request for a rehearing.[47]

As they appealed the case, the FWHC and their legal team lost no time in seeking to shed light on what they saw as the physicians' ludicrous, self-serving interpretation of their professional organizations. The FWHC also tried aggressively to force the Capitol Medical Society in specific to take a side in the matter themselves and declare themselves to be either a public body and a legitimate statutory regulator—which would make the CMS subject to governmental transparency

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[46] Alan Kusinitz, "Seventh Circuit Closes a Loophole in the *Noerr-Pennington* Doctrine" *Antitrust/Competition Perspectives* (November 2, 2011). https://antitrust.weil.com/seventh-circuit-closes-a-loophole-in-the-noerr-pennington-doctrine/. Accessed November 10, 2016.

[47] Tallahassee Feminist Women's Health Center, Press Release "Feminists' Request for Rehearing Denied," February 24, 1977. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.12. Schlesinger Library, Harvard University.

requirements, for instance in regard to financial and other conflicts of interest—or affirm that they were a fully private organization and therefore devoid of legal regulatory authority.[48] When, in January 1977, the Capital Medical Society issued a press release in which they stated that the Florida Attorney General had issued an official opinion that Florida's "Government In the Sunshine" transparency law did not apply to medical organization activities, however, they explicitly did not relinquish the claim to regulatory authority.[49] Instead, they used the Attorney General's opinion merely to affirm that in the eyes of the state, the CMS was not obligated to obey government transparency statutes.

A definitive decision on the applicability of Noerr-Pennington doctrine to *Feminist v. Mohammad*, and thus on the triability of the FWHC's claims of conspiracy to inhibit trade and disrupt interstate commerce, had to wait for the acceptance of the petition for rehearing by the Fifth Circuit Court of Appeals. In their decision to hear the appeal, Judges Homer Thornberry and Alvin Rubin immediately expressed questions concerning the scope of the Noerr-Pennington defense.[50] The Fifth Circuit Court's acceptance of the case communicated an expectation that a Noerr-Pennington defense would be held to high standards of scrutiny for motive. It is clear from their language in the decision that Judges Rubin and Thornberry were skeptical of the defense, and inclined to a deregulationist stance, stating that evidence of damage to the plaintiff was not mandatory in order to look at the question of whether "the defendants were not dangerously close to possessing monopoly power."[51] Furthermore, the judges referenced the recent *Goldfarb* decision (421 U.S. 773, 1975),

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[48] Tallahassee Feminist Women's Health Center, open letter "Which is it, Capitol Medical Society: Public or Private?" December, 1976. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.12. Schlesinger Library, Harvard University.
[49] Capitol Medical Society, Press Release, January 10, 1977.Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.12. Schlesinger Library, Harvard University.
[50] Feminist Women's Health Center Inc., v. Mahmood Mohammad, et al. 586 F.2d 530, December 20, 1978, paragraph 1.
[51] Feminist Women's Health Center Inc., v. Mahmood Mohammad, et al. 586 F.2d 530, December 20, 1978, paragraph 40.

which had determined that lawyers engaged in "trade or commerce" and thus had no antitrust immunity.[52] The Fifth Circuit Court of Appeals judges, meanwhile, were liberals confidently riding the wave of 1970s legislative and political revisionism with regard to the old guard power of the learned professions and the Sherman Antitrust Act. Ideologically, they saw no reason that the AMA and its members should not be taken down a notch and deprived of some of their inherited customary power. In their decision, Rubin and Thornberry dismissed the Noerr-Pennington defense as inapplicable, stating that "we are not persuaded…that [a law previously interpreted as giving medical review organizations regulatory purview] makes medical review organizations public regulatory bodies."[53]

Habitual and customary regulation within professional associations, in short, did not actually translate into statutory regulatory force. Deregulation, more typically a matter of rolling back state regulation of industry in order to encourage competition, takes the form in *Feminist v. Mohammad* of limiting the power of the professional association—power previously extended by the state as a professional (and class-based, and overwhelmingly racialized) courtesy—to authoritatively regulate its associated industry. This form of deregulation shares the same goal as the more orthodox version, however: deregulating allows and encourages competition. It is politically strange for a feminist organization critical of capitalism to end up being the vehicle for a neoliberal economic strategy like industrial deregulation, in the same way that it was strange for such a feminist organization to choose a foundationally capitalist mode for addressing its grievances in the first place. Yet it is simultaneously true that in their focus on economics and competition both the

[52] Feminist Women's Health Center Inc., v. Mahmood Mohammad, et al. 586 F.2d 530, December 20, 1978, paragraph 67.
[53] Feminist Women's Health Center Inc., v. Mahmood Mohammad, et al. 586 F.2d 530, December 20, 1978, paragraph 37.

strategy and the outcome legitimized the small feminist clinic in a socially and politically meaningful way.

In their reflexive petitioning of their professional organizations, Tallahassee's physicians betrayed their sense of entitlement to have their social power and "learned professions" immunity insulate their behavior from public accountability. But when Thornberry and Rubin pulled away the curtain of AMA immunity and refused to allow professional associations to be claimed as essentially governmental, the venal and conspiratorial aspects of the physicians' behavior grew harder and harder to defend. The physicians ultimately chose to forfeit a verdict, settling out of court with a paltry $75,000 in damages and injunctive relief awarded to the Feminist Women's Health Center. Further, having lost the ability to lean on professional immunity from being held accountable for their actions, Tallahassee Memorial Hospital agreed to a formal hospital transfer agreement with the FWHC, ending several years of surreptitious agreements with local doctors to provide post-abortion care. Equally conciliatory was the settlement concession by George Palmer, Executive Director of the Board of Medical Examiners, who finally admitted that the Board had no jurisdiction over the FWHC *per se*, and would discontinue keeping files on the clinic.[54] The physicians and even the Board of Medical Examiners, faced with jurisprudential unwillingness to accept their exceptionalist arguments, proved capable of coexistence with the FWHC after all.

It was, however, too little and far too late to save the Tallahassee FWHC. The damages awarded were inadequate even to pay the FWHC's legal costs, and TFWHC ended up at odds with their lawyers over the damages awarded. The lawyers, understandably, wanted to be paid for their services, and knew themselves to be legally entitled to payment from the damages awarded. The

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[54] *Feminist v. Mohammad* Stipulation and Joint Motion to Dismiss, U.S. District Court for the Northern District of Florida, Tallahassee Division, January 14, 1980. Records of the Women's Community Health Center, Cambridge, MA, 1953-1987, Folder 15.12. Schlesinger Library, Harvard University.

TFWCH, understandably, wanted to try to keep themselves afloat. Despite a lawsuit filed against the clinic by its lawyers, neither got what they wanted in the end. The Tallahassee Feminist Women's Health Center did not long outlast the end of *Feminist v. Mohammad*.[55]

When viewed simply as an anti-trust case, *Feminist v. Mohammad* appears relatively uneventful, an unremarkable case of trade interference whose small stakes makes it seem almost petty. By looking past the surface of the case to see what events impelled the filing of a law suit, the reasons behind the choice to use the Sherman Anti-Trust Act as the vehicle for the suit, the mechanisms the defendants attempted to use to protect themselves, and the judicial outcome of the suit, however, we discover a rich display of multiple social, political, and economic forces at play in the mid- and late 1970s. Tensions around feminism, gender, medicine, and professional legitimacy were translated, thanks to impressionistic and experientially-grounded concerns about Southern political and social conservatism, into a legal medium centered on and in economics, and theoretically as divorced as a legal case could be from contentious realms of social ideology and political reform. Yet even in the medium of pure anti-trust economics, *Feminist v. Mohammad* participates in, and thus helps to illuminate, a different realm of social ideology and political reform characteristic of its era, the realm of industrial deregulation.

When viewed, by contrast, as a legitimation of feminist health, *Feminist v. Mohammad* is more significant: it establishes the participation of feminist and other alternative health organizations as no longer so much on the fringes of either mainstream society or the mainstream medical industry. This gave other feminist health organizations a much-needed boost in their sense of their own validity as economic and social entities (they did not lack that sense of validity in terms of their politics). Indeed, The Chico, California, Feminist Women's Health Center would, a few years later,

[55] Stinson interviewed by author, 1 November 2016.

attempt to replicate the Tallahassee clinic's success with an antitrust suit, a move it would likely not have made without Tallahassee's legal and activist precedent.

What *Feminist v. Mohammad* did not and could not do, however, was relieve the TFWHC's precarity or that of any other feminist health organization. The stinging irony revealed by the Tallahassee suit was that the victory was Pyrrhic: a feminist health organization could win a striking legal victory against the "old boys' network" and the traditional medical industry, yet not survive the experience. The traditional medical industry and the network of Tallahassee doctors may have learned a thing or two about tangling with feminist health activists, but in the end also got precisely what they had wanted in the first place, the dissolution and disappearance of the Tallahassee Feminist Women's Health Center. In the annals of the feminist women's health movement, *Feminist v. Mohammad* surely stands as a landmark and a bold sign of changing times and mores where it comes to industrial regulation and independent medical providership. But it also stood as a pointed reminder to health feminists that, as Audre Lorde famously put it, "the master's tools will never dismantle the master's house."[56]

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[56] Audre Lorde, "The Master's Tools Will Never Dismantle the Master's House" *Sister Outsider: Essays and Speeches* (Berkeley, CA: Crossing Press., 1984), 110- 114.

Chapter Two

Divided Loyalties:

The Mari Spehar Health Education Project, Fayetteville, Arkansas, 1977-1982

Short-lived and never entirely definite about its mission or goals, the Mari Spehar Health Education Project was created by a group of women living in and around Fayetteville, Arkansas in 1977, and existed in some form or another until 1982. Because of its complicated enmeshment in the countercultural communities of a small and geographically isolated college town in a largely rural and mountainous region, MSHEP's history and activities look little like any of the other feminist health organizations profiled in this project. In fact, by comparison to the other organizations in this study, MSHEP did very little feminist health care provision at all.

Perhaps ironically, this fact is one of the ways that as a case study, the Mari Spehar Health Education Project usefully illuminates some otherwise obscured aspects of the overall picture of feminist health in the South. Normally, historians don't spend much time on organizations that never quite coalesce and fail to do what they nominally propose to do. Yet I argue that these sorts of flashes in the proverbial pan can sometimes, in fact, tell us things that more fully developed and productive organizations cannot. Organizations fail all the time. Many of them fail for roughly the same tedious reasons, such as the perennial problem of financial mismanagement. But sometimes organizations fail for far more interesting reasons, and when they do, it can be instructive to understand them historically. The life of the Mari Spehar Health Education Project [MSHEP], such

as it fitfully was, reveals a collection of unusual and perhaps unique conditions related to its geographical location not only in the rural Ozark south but that location's relationship to specific and sometimes conflicting social and cultural movements of the 1960s and 1970s. Unchronicled elsewhere in the feminist health historiography, the MSHEP

Politically, demographically, geographically, and socially, 1970s Fayetteville was fundamentally different to the larger southern cities where most other feminist health organizations came to life. Where the other feminist health organizations profiled in this study came to life in urban areas of moderate to large size with well-developed and diverse economies, Fayetteville in the second half of the 1970s was a small university town nestled in the overwhelmingly rural and agricultural Ozark mountains. It was growing, however, and in a rather distinctive way. Despite the presence of the state's flagship public university, Fayetteville in 1960 was a town of only a little over twenty thousand. By 1970, however, Fayetteville's population swelled to nearly thirty-one thousand, and numbers in its surrounding county, Washington County, had grown from 57,797 to 77,370.[1]

Because of the presence of the University of Arkansas, Fayetteville's demographics had long skewed youthward. But the '60s and '70s brought large numbers of young adults to the area who were not necessarily there to get a university education. Rather, they had come to northwestern Arkansas to go "back to the land" as members of the liberal/alternative counterculture and the "land movement." Their agenda, which was simultaneously political, economic, and cultural, focused on homesteading, small farming, self-sufficiency, and anti-statist, anti-establishment rurality.

The Arkansas Ozarks had long attracted independent-minded individuals searching for a place to homestead. As early as 1910 William R. Lighton's stories of his move to Fayetteville, published in *The Saturday Evening Post* as "The Story of An Arkansas Farm" captivated the imagination of thousands who wrote to or even went so far as to visit Lighton to find out how they

[1] City of Fayetteville, Arkansas, Office of Public Records. Email communication with author, April 19-30, 2017.

too might trade what they increasingly saw was an impersonal and unrewarding urban industrial world for "the healthiest place in the world" where "failures are unknown" and a twenty-acre homestead could be had for as little as $25.[2] Although the back-to-the-land movement began with writer-farmers like Lighton, its *locus classicus* for most familiar with it today was its post-Summer of Love incarnation. In her 1970 song "Woodstock," singer-songwriter Joni Mitchell rhapsodized about going rural with a line that resonated loudly with her generation: "got to get back to the land and set my soul free."[3]

Land movement historian Dona Brown, in her 2011 *Back to the Land: The Enduring Dream of Self-Sufficiency in Modern America*, connects this 1960s-1970s intensification of the land movement to iconic moments of violence, the breakdown of trust in the political system, and economic crisis in White America: the Kent State massacre, Watergate, and the 1973 oil embargo.[4] Earlier back-to-the-landers had often effectively been economic migrants looking for a path to self-sufficiency that could insulate them from the economic and psychological slings and arrows of industrial wage work and boom-or-bust cycles, Dust Bowls and Depressions. The 1970s version additionally sought an escape from what appeared to be an increasingly corrupt and unjust political and economic establishment whose operations polluted the environment and erased individuality and expressiveness.[5] As a political statement, 1970s back-to-the-land activity revolved around the gesture of physically and economically removing one's self from "the Establishment" whilst

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[2] Dona Brown, Back to the Land: the Enduring Dream of Self-Sufficiency in Modern America (Madison, WI: University of Wisconsin Press, 2011), 56.
[3] Joni Mitchell, "Woodstock" *Ladies of the Canyon* (Los Angeles, A&M Studios / Reprise Records, 1970), track 11.
[4] Brown, 206.
[5] Brown, 209-212.

creatively (if largely symbolically) repairing its manifold damages through voluntary simplicity and environmentalism.[6]

In part because of its removal from more populous and urban contexts and their social concomitants, the land movement coexisted uneasily and uncertainly with social justice movements such as civil rights and feminism. Few back-to-the-landers were people of color, and while many participants were female, many heterosexually-identified women in the land movement found that "back to the land" often meant going back to the onerous burden of "women's work" done as their great-great grandmothers had done it: entirely through manual labor.[7] Themes of independence, freedom, and principled self-direction were certainly common to both mainstream second-wave liberal feminism and the land movement, but what those things looked like was not the same in both movements. Although many women in the land movement identified as feminists or as supporters of women's liberation, the feminism that existed within the land movement was in many ways not the feminism that animated the national mainstream feminist efforts like the effort to ratify the ERA or achieve equal pay legislation. Mainstream feminists of the so-called second-wave worked largely within in a mode of classical liberal civic politics. They engaged in deliberately chosen analytical, persuasive, and legislative grappling with mainstream society and the state in consistent attempts to force the broader culture to engage with feminist concerns and, eventually, reform itself.[8] The land

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[6] There is an extended discussion of the priority and spiritualization of voluntary simplicity within the land movement in Jeffrey Jacob, *New Pioneers: The Back-to-the-Land Movement and the Search for a Sustainable Future* (University Park, PA: Pennsylvania State University Press, 1997), 92-96. On the role of environmentalism see Brown, 213-215.

[7] Keridwen Luis writes about the struggles of women of color in the lesbian land movement to achieve access to land and places to settle, and the ultimate establishment of a few lands expressly dedicated to women of color. See Keridwen N. Luis, *Herlands: Exploring the Women's Land Movement in the United States* (Minneapolis: University of Minnesota Press, 2018, 45-72. Brown notes that "…the 'handmade life' often appeared liberating (at least at first) to back-to-the-land women of this generation. Outhouses and woodstoves seemed far from the sanitized suburban emptiness of Betty Friedan's 'problem with no name.' (Brown, 212)

[8] There was, of course, a secessionist wing to the second wave feminist movement. Indeed, lesbian separatism often combined with back-to-the-land activity, creating a fascinating and remarkably robust collection of women's lands or dyke lands, some of which are still extant. Several well-known women's lands existed in the Ozarks in the general vicinity of Fayetteville across the 1970s and 1980s, including Yellowhammer, Sassafras, Arco Iris, Whipporwillow, Spinsterhaven, and the Ozark Land Holding Association (OHLA). Arco Iris, OHLA, and

movement, by contrast, took place largely in a mode of deliberate and principled *dis*engagement and self-removal from the cultural and political mainstream, aspiring not to reform society but to build an alternative new world, leaving the old one to its chances.

Therefore it is crucial to the present analysis to recognize that many Fayetteville women who became active in the women's community and in the Mari Spehar Health Education Project, including Mari Spehar herself, were invested in and influenced by the land movement, even if not all of them participated by living on land or homesteading. This is relevant because the diffuse progressivism of the 1970s land movement and its surrounding generalized counterculture was decentralized, frequently politically incoherent, and often not given to community organizing beyond the level of the household or commune.[9] [10] In interviews with MSHEP founders, several of whom were connected to and involved with the land movement, a picture emerges of women who shared a progressive mindset and were committed to social change movements, but had no substantive feminist analysis, experience with feminist consciousness-raising, or workable feminist activist methods in hand.

Rather than operating within a classic liberal feminist mode in which citizen activism encourages movement toward a more egalitarian civil society, these women's approach to feminist change tended to have more to do with a willingness to rely on a variety of gender essentialism. They believed that women's innate or "natural" capacities would, if not interfered with by "the Establishment," allow women to live better lives and interact more ethically with others. Women

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Spinsterhaven still exist in some form. See Allyn Lord and Anna M. Zajicek, *The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970-2000.* (Fayetteville, AR: No Publisher Given, 2000) and Allyn Lord, Anna M. Zajicek, and Lori Holyfield, "The Emergence and First Years of a Grassroots Women's Movement in Northwest Arkansas, 1970-1980" *Arkansas Historical Quarterly* 62 (Summer 2003): 153-181.

[9] Brown, 216-220.

[10] Women's lands and lesbian lands were formed within the land movement, but these were still based in a politics of self-removal and avoidance of the matrix culture: they were not trying to change the larger culture, only create their own, and the tools they used were different than the ones used by feminists working for change from within mainstream society.

could, some believed, create wholesale change through these organic capacities, and therefore women had a shared role as change agents simply because they were women.[11] Such beliefs were not limited to women involved in the land movement. In *This Bridge Called My Back*, a landmark of second-wave women's liberation political thought first published in 1981, Gloria Anzaldúa described a feminist future she imagined as a "left-handed world" that rested on "women…having tremendous powers of intuition experiencing other levels of reality and other realities" and a "reemergence of the intuitive energies."[12] This would, she imagined, create a world in which "the colored, the queer, the poor, the female, the physically challenged" would all be welcomed and at ease and that thanks to "our blood and spirit connections with these groups, we women at the bottom throughout the world can form an international feminism."[13] This cultural, essentialist approach to feminism made an easy match for the antiestablishment and ecological politics of the back-to-the-land movement, and for its deeply rooted quasi-spiritual ethos of connection with "the natural," including the natural world and ideas of the "natural self" and "natural living."[14] Thinking about women and women's roles in society in terms of a mythic feminine intrinsically connected to land, the "naturalness" of indigeneity, and the immediacy of unmediated phenomena like intuition, insight, and "blood and spirit connections" suited the ethos of a movement that centered around the notion of making an agrarian, roots-focused break from mainstream society and its manifold ills.

The story of Mari Spehar Project founding member Ginny Masullo's path to Fayetteville helps exemplify how these ideas influenced individual women who became interested in feminist

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[11] For further discussion of the distinctions between liberal and cultural modes of feminism see e.g. Josephine Donovan, *Feminist Theory: The Intellectual Traditions,* Fourth Edition (New York: Continuum International Publishing Group, 2012) particularly Chapter 7, "Twentieth Century Cultural Feminism."
[12] Cherríe Moraga and Gloria Anzaldúa, *This Bridge Called My Back: Writings by Radical Women of Color* (Watertown, MA: Persephone Press, 1981), 223.
[13] Ibid., 196.
[14] Rebecca Gould discusses this ethos in detail in *At Home in Nature: Homesteading and Spiritual Practice in America* (Berkeley, CA: University of California Press, 2005).

health. Masullo, a native Texan, came to Fayetteville as a land movement migrant. In the early 1970s, while living on a land movement settlement in northern Washington State, she had given birth to her first child in a tipi "ten miles from the Canadian border."[15] With her partner she had returned south to allow her Texan parents to meet their new grandchild, and although the young family considered settling in liberal, hippie-heavy Austin, Texas, they found it to be too urban for their tastes despite its countercultural appeal.

Masullo, baby, and partner thus migrated to the Ozarks to resume their search for a land-based life. They had become "used to living in the country, and wanted to get back to the country. We heard Fayetteville was a little Austin [Texas], so we moved out in the country and it was a pretty isolated life."[16] As it did for other Ozark back-to-the-landers, Fayetteville served as general supply depot and social hub. Both functions centered around the food co-op, which remains a robust business and community center, now known as Ozark Natural Foods.[17] An index of the degree to which the food co-op remains central to the community, as well as of the degree of strength of the Fayetteville left communities even today, can be found in the fact that when I visited the co-op and introduced myself, I rapidly found myself speaking to three people who were in the co-op at the time who had in some way been connected to the Mari Spehar Health Education Project. One of them had even briefly been among Spehar's housemates, and quickly, happily whipped out his cellular phone and connected me to several interview subjects as I stood in front of the prepared foods case.

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[15] Ginny Masullo, interviewed by Hanne Blank, 2 February 2017.
[16] Ginny Masullo, Interview transcript, n.d. Summarized in Lord, Allyn, and Anna M. Zajicek. *The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970–2000*. Fayetteville, AR: 2000.
[17] Masullo interview, 2017. See also remarks in various of the Interviews n.d., summarized in Allyn Lord and Anna M. Zajicek. *The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970–2000*. (Fayetteville, AR: No Publisher Indicated, 2000).

Having experienced the social vigorousness of the co-op in 2017, I was all the more easily able to appreciate its role and its importance in the 1970s when Ginny Masullo turned to it as a resource to help her deal with rural isolation. Through the food co-op, Masullo found her way to various manifestations of Fayetteville's countercultural communities, including support groups, alternative healing circles, and the Women's Center affiliated with the University of Arkansas.[18] All of these groups provided friendships—some of which would prove to last decades—and support that sustained Masullo when she chose to leave the father of her son. Now a young single mother needing an income to support herself and her child, Masullo left the back-to-the-land life and moved in to town. Once in Fayetteville, she would end up sharing living space as a housemate with a young woman carpenter from Detroit who had come to Fayetteville in order to live closer to the land and closer to her antiestablishment, "alternative" values. That housemate was Mari Spehar.[19]

The Brief Life and Horrible Death of Mari Spehar

On March 14, 1977, at 1:30 in the morning, Mari Spehar was declared dead at Gravette Medical Center in Gravette, Arkansas. Her death was startling and unexpected: Spehar was not merely young, but a dark-haired, dark-eyed, athletic, vigorous, and daring young woman, a skilled carpenter who practiced tai chi and was deeply invested in alternative health practices. About two years prior to her death she had moved from her home town of Detroit, Michigan to Fayetteville, Arkansas as a member of the informal and highly mobile community of "counterculture" young adults—like the young Ginny Masullo and her partner—looking for a more rural life. Spehar was a visible and celebrated part of the Fayetteville counterculture and the women's community. In a profile published in the local women's newsmonthly *Hard Labor* in October, 1975, she was lauded for her

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[18] Masullo interview, 2000.
[19] Ibid.

competence as a craftswoman and quoted as saying she wanted to teach carpentry to other women and create a women's carpentry collective.[20] Notes and meeting minutes from various women's groups affiliated with the Fayetteville Women's Center reveal her attendance at meetings on topics like herbal medicine, natural birth control, and gynecological self-care.[21]

Even as Spehar learned about herbal remedies, renovated old Fayetteville houses, and introduced new friends to tai chi, however, her body was becoming a time bomb. At the age of 20, Spehar had done what hundreds of thousands of other sexually active women who did not wish to become pregnant had done, and arranged to have a doctor insert an IUD in her uterus. The IUD her doctor chose was the now-infamous Dalkon Shield, a small plastic device inserted into the uterus to disrupt the potential implantation of any fertilized eggs. It proved a disastrous choice.

The Dalkon Shield entered the market in 1971, and proved almost immediately to be a harmful medical appliance whose poorly designed removal string introduced dangerous bacteria into the uterus, frequently leading to Pelvic Inflammatory Disease and sometimes to infertility due to scarring. Sometimes the Shield led to uterine infections that progressed to sepsis; sepsis sometimes resulted in death. By 1974, 17 deaths had been formally attributed to the device in the USA.[22] Although the product was sold for only a few years in the United States, more than 300,000 lawsuits were filed against the manufacturer. The scandal, when the magnitude and prevalence of these side effects came to light, was enough to bankrupt its manufacturer, A.H. Robins. The safety reputation

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[20] Leslie Parr and Harriet Jansma, "Working Women in Northwest Arkansas" *Hard Labor* 3 n.1 (October 1975), 1, 4-5. Fayetteville Women's Library Feminist and LGBT Publications Manuscript Collection Box 2, Folder 25. University of Arkansas Special Collections.

[21] Fayetteville Women's Center Health Collective, Meeting Notes, February 10, 1975. Fayetteville Women's Library Archives Box 26, Folder 26-12. University of Arkansas Special Collections.

[22] Barbara Ehrenreich, Stephen Minkin, and Mark Dowie, "The Charge: Gynocide; The Accused: The U.S. Government" *Mother Jones* (November/December 1979). Accessed online at http://www.motherjones.com/politics/1979/11/charge-gynocide, 6 March 2017.

of IUD technology was so badly damaged by the Dalkon Shield's catastrophic side effects that the American market for IUDs did not rebound for thirty years.[23]

Spehar was one of the Dalkon Shield's many victims. The story of her illness and death, however, illuminates much more than just the dangers of a notorious piece of medical technology. Mari Spehar's life, not unlike the trajectory of the health education project named in her memory, was complicated and compromised by multiple loyalties and, at times, by ambiguous priorities. The lives of both the woman and the health project were shaped by a justified skepticism of establishment and mainstream authority, but also by a sometimes overly credulous, politically motivated trust in "alternative" and "countercultural" sources of authority. All of these contributed to the conditions of Spehar's sickness and death, and all these things also contributed to the feminist health organization which bore her name ultimately failing to achieve its goals.

Based on the published recollections of her friend Ginny Houghton, Spehar was implanted with her Dalkon Shield device for a total of five years, of which the first three were apparently unproblematic. Eventually, however, Spehar began to experience symptoms including prolonged, excessive, and painful uterine bleeding. Believing that her symptoms stemmed from the IUD, Spehar went to two different gynecologists with the specific intent of having the Dalkon Shield removed. The first physician examined Spehar and informed her that the IUD's removal string, which under normal circumstances should have been visible at the opening of the cervical os, was not present. Although spontaneous ejection of the Dalkon Shield was uncommon due to its shape, the physician perhaps presumed this was the case as nothing further was apparently done. A second physician verified that the string could not be seen. This doctor, however, decided to double check, and dilated Spehar's cervix to see whether he could detect the IUD within the uterus. Apparently

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[23] Anna Bahr, "As memories of Dalkon Shield Fade, Women Embrace IUDs Again" *Ms. Magazine Blog* (August 29, 2012). Accessed at http://msmagazine.com/blog/2012/08/29/as-memories-of-dalkon-shield-fade-women-embrace-iuds-again/ on 6 March 2017.

this physician also failed to detect the IUD, and he told Spehar that it must have been ejected. But Spehar continued to experience painful and disruptive uterine symptoms, and they continued to get worse.[24]

It appears to have been soon after these two disappointing experiences with gynecology that Spehar moved from her native Detroit, Michigan, to Fayetteville. Oral histories inform us that after arriving in Fayetteville, Spehar availed herself of the array of nutritional therapies, herbal medicine, homeopathy, chiropractic, and other alternative health practices available within Fayetteville's counterculture community.[25] This was very much in keeping both with the counterculture of the time, with its notorious lack of trust in the traditional medical establishment, but also with the more specific history of the Ozarks, whose geothermal hot springs had made them a locus for water cures and other alternative medical modalities since the nineteenth century.

This legacy was due in part to what historian Conevery Bolton Valenčius refers to as the specific medical geography of the Ozarks. As European-descended settlement spread west of the Mississippi during the nineteenth century, Valenčius explains, settlers' careful study of the landscape and its features allowed them to assess the land as being variously healthful, pernicious, or someplace in between.[26] The presence of hot and mineral springs was considered particularly wondrous and beneficent, reassuring "grime-encrusted, mosquito-bitten travelers that their God had endowed the world judiciously with resource as well as threat."[27] The fact that both their European ancestors and the indigenous Americans with whom they often came into contact on their westward path likewise appreciated and used natural springs for bathing, spiritual practices, the treatment of

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[24] Ginny Houghton, "The Death of Mari Spehar" *Hard Labor* (March 1977), p. 4. Fayetteville Women's Library Collection, Box 2, Folder 2-7, "Mari Spehar – 1974-1982 – Health Ed Project." University of Arkansas Special Collections; Carole Cimarron interviewed by Hanne Blank, 2 February 2017; Masullo Interview, 2000.
[25] Houghton 1977; Cimarron 2017; Masullo 2017.
[26] Conevery Bolton Valenčius, The Health of the Country: How American Settlers Understood Themselves and Their Land (New York: Basic Books, 2002), 161-167.
[27] Valenčius, 153.

illness, and more reinforced their importance.[28] Even before the late nineteenth-century development of Arkansas spa towns like Hot Springs or Eureka Springs (respectively 183 and a mere 42 miles from Fayetteville) indigenous residents, travelers, and settlers all depended upon the natural springs for a variety of purposes.

As travel to Arkansas became easier and the spa towns sprouted up in the nineteenth century, hydrotherapy was not the only recourse available for the weary, the ill, and the disabled. They had their pick of contemporary alternative health practices. Some, like vegetarianism, stemmed from the same hygiene-based understanding of health that supported hydrotherapy. Proponents of this school of medical thought, albeit a century apart, famously included Sylvester Graham and John Kellogg, both of whom encouraged cold-water bathing, plenty of drinking water, a vegetarian diet, and other wholesome pursuits in order to purify and calm the body's irritations. The lengthy history of hydrotherapy in Europe and North America that opens Susan E. Cayleff's *Wash and Be Healed: The Water-Cure Movement and Women's Health* demonstrates not only the hygiene model's American popularity but its lengthy, respectable European pedigree.[29] The theory, in essence, ran that health was the natural condition of the body and disease the unnatural state, and that applications of water would disrupt foreign and harmful matter, bring about an acute crisis of expulsion of what we now might term "toxins," and then assist the body in keeping itself pure of such adulterants so that it could heal.

In these spa towns, other health practices ranging from massage to homeopathy were often combined with hydrotherapy. Various forms of exercise were prescribed, particular foods taken or abstained from, and spiritual therapies such as prayer often also played a role. Traditional allopathic medicine and its drugs and surgeries, however, were unwelcome, as was allopathy's definition of

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[28] Valenčius, 152-158.
[29] Susan E. Cayleff, *Wash and Be Healed: The Water-Cure Movement and Women's* Health (Philadelphia: Temple University Press, 1987), 19-39.

illness as pathological.[30] This was particularly true with regard to "female troubles," any of a wide range of women's reproductive maladies, which overwhelmingly brought women to the use of hydrotherapeutic regimes. Indeed, hydrotherapeutic medicine was among the first Western practices to suggest that in general, women's reproductive physiological processes were utterly normal and healthful and would remain so as long as women's bodies had been brought into a state of carefully maintained good hygiene.[31] Nestled amongst the hot springs-rich Ozarks as it was, Fayetteville bobbed like a dumpling in a rich soup of popular non-standard health practices, establishing a strong tradition of alternative medical views and practices that persisted long beyond the heyday of Hot Springs and its spas and casinos.

Perhaps, in an environment with this history, it was more likely than not that Fayetteville would become a hub for the free-thinking and the iconoclastic. Perhaps it is also one of the historical forces that encouraged Mari Spehar to try a range of methods and remedies for her increasingly disruptive and painful problems. Eventually, in February of 1977, Mari Spehar became frustrated with her chronic, intensifying, and apparently intractable pain and bleeding, and once again went to a physician. This physician diagnosed a vaginal infection, but suggested that exploratory surgery might be necessary to determine the cause. Spehar was torn. As an uninsured freelance carpenter, surgery would have been unaffordable. She did not want to have to ask her family and friends for help. On the other hand, she was miserable and her quality of life had been impinged upon for some time. For a week, she mulled it over, but then things took a turn for the worse, and Spehar began to experience severe abdominal cramps in addition to the pain and bleeding. She returned to the same physician, who told her she had the flu and sent her home. The

[30] Susan E. Cayleff, *Wash and Be Healed: The Water-Cure Movement and Women's* Health (Philadelphia: Temple University Press, 1987), 52-53.
[31] Cayleff, 53-66.

following night she was in such pain that she wanted to go directly to the hospital. She did not do so, however, because her doctor had just dismissed her from care as having only a minor malady.[32]

Instead of going to the emergency room of a traditional hospital, then, on or about March 5, 1977, Spehar headed to a natural healing center near Sulphur Springs, Arkansas, one of the many smaller spa towns that had flourished with the nineteenth-century vogue for hydrotherapy. Correspondence with Don Warden, director of the Siloam Springs Museum in Siloam Springs, Arkansas, has yielded the suggestion that Spehar's most likely destination was the Philadelphian Homes healing retreat in Sulphur Springs, run by one Dr. Holmes, who had lost her conventional medical licensure. The Philadelphian Homes retreat was located very near the Gravette Medical Center, where Spehar was later pronounced dead.[33] Over the course of four days, Spehar grew weaker and weaker until finally she suffered cardiac arrest. She was revived and rushed to a nearby hospital, Gravette Medical Center, where emergency surgery revealed that a badly infected fallopian tube had burst, introducing the infection into Spehar's peritoneal space and causing sepsis. At Gravette, Spehar's infected fallopian tubes and ovaries were surgically removed.[34] Spehar did not regain consciousness after this surgery. She lay comatose for five days before dying, a casualty of the Dalkon Shield.

Mari Spehar's death is, in many ways, almost a perfect cautionary tale from the standpoint of feminist health. First, she died due to complications from her Dalkon Shield IUD, which at the time of her death was becoming increasingly known both to feminists and to physicians as dangerous. Feminists had already begun sounding the alarm and pushing for the Dalkon Shield's removal from the market.[35] Second, Spehar's interactions with traditional medicine were emblematically

[32] Houghton, 1977.
[33] Don Warden, Siloam Springs Museum, personal correspondence with the author, March 14, 2017.
[34] Houghton 1977; Cimarron 2017. Patient privacy laws have precluded the verification of these reports.
[35] Ehrenreich et al., 1979.

inadequate and dismissive, very much to Spehar's detriment as a patient, a pattern within male-dominated gynecological practice that was at the heart of health feminist outrage and reform.[36]

But if mainstream Western medicine failed to prevent Spehar's miserable, lingering demise, the alternative medical options beloved of the counterculture in which Spehar lived did no better. Neither did they give her tools or methods to protect herself from mainstream medical mismanagement or malpractice. In fact, an allegiance to counterculture identity and counterculture-identified healing practices may have done Spehar more harm than good.

Research by both Michèle Dominy and Keridwen N. Luis has shown, that countercultural or subcultural identity may include an aspect of purity politics in which one's adherence to the behavioral priorities set by that subculture is part of how members of the subculture acquire and measure cultural capital.[37] In other words, it is possible that to the degree that Mari Spehar sought alternative health treatments over traditional medical interventions even in her final illness, she may have done so in part because of a belief that doing so was superior, reflective of the antiestablishment values of the community whose acceptance and approbation she depended upon.[38] In a February 2017 interview, Fayetteville feminist Carole Cimarron, a contemporary and friend of both Spehar and Masullo, unabashedly offered the view that "Mari's choices had a lot to do with her

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[36] Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (New York: Praeger Publishers, 1978), 33-52.

[37] Keridwen N. Luis, "Karma Eaters: The Politics of Food and Fat in Women's Land Communities in the United States" *Journal of Lesbian Studie*s 16 n. 1 (January 2012), 122-123, 128; Michèle D. Dominy, "Lesbian-Feminist Gender Conceptions: Separatism in Christchurch, New Zealand" *Signs* v. 11 n. 2 (Winter 1986), 278-279, 283-284.

[38] Cimarron interview, 2017. Cimarron, a nurse who later became a CDC-trained epidemiological researcher, also noted that at the time of her death Spehar had been in a romantic relationship with a man who owned Summercorn, a Fayetteville natural foods vegetarian restaurant and bakery. This man's laissez-faire attitudes toward "establishment" health concerns and sanitation laws would ultimately contribute to an outbreak of nearly 150 Hepatitis A cases in Fayetteville during November and December 1978, a case so illustrative that it has been widely used in U.S. Centers for Disease Control training material and in major epidemiology textbooks such as Randy Page, Galen Cole, and Thomas Timmreck, *Basic Epidemiological Methods and Statistics: A Practical Guidebook* (Boston: Jones and Bartlett, 1995), 319-320. In the absence of archival evidence it would be irresponsible to speculate on what this man's influence on Mari Spehar's healthcare decisions might have been, and yet it seems possible that there could've been some. Interpersonal relationships of many types create community and transmit community values.

death. The community then was smaller, and pretty hardcore anti-medicine back-to-the-land…. Western medicine was evil."[39]

Like many back-to-the-landers, many alternative medical practitioners have, since the Popular Health movement of the early 19th century, deliberately distanced themselves from a system of practice they viewed as wrongheaded, decadent, corrupt, and harmful. Again like back-to-the-landers, many alternative health practitioners have believed that leaving a hegemonic, fatally broken system was the best critical response they could make.[40] But dropping out of a flawed system guarantees only blanket condemnation, not critical engagement, reinvention, or reform.

Spehar died young and she died horribly, but her death did, ultimately, spur reinvention and reform-minded activist engagement with medicine in her community of drop-outs and back-to-the-landers. In the wake of Spehar's death, the question of how such a tragic loss might have been prevented galvanized her grieving friends. This question propelled the creation of the Mari Spehar Health Education Project.

The Mari Spehar Health Education Project

In the immediate wake of Spehar's death, Fayetteville counterculture community mourned the loss. Women involved in the informal community surrounding the university Women's Center, in particular, gathered to grieve together and talk through the shock of losing a friend so vibrant, independent, feminist, and strong. Their response, ultimately, was to decide to create the Mari Spehar Health Education Project. It was conceived as an organization that could provide woman-

[39] Cimarron interviewed by author, 2017.

[40] Joan Burbick, *Healing the Republic: The Language of Health and the Culture of Nationalism in Nineteenth Century America,* Cambridge Studies in American Literature and Culture, ed. Eric Sundquist (New York: Cambridge University Press, 1994), 3.

controlled health advice, education, and, perhaps one day, clinical services with the aim of improving women's health and preventing further tragedies like Spehar's. Neither the memorial gathering nor the creation of the MSHEP took place in a vacuum, however. They piggybacked on, adopted, and adapted resources that already existed through and within the Women's Center affiliated with the University of Arkansas. The organizational power of the Women's Center provided both a metaphorical and a literal springboard for the MSHEP's work.

In principle a project under the sponsorship of the University of Arkansas, at the time of Mari Spehar's death the Women's Center was a women's community center whose reach far exceeded the campus. The university had granted a core group of women the use of a university-owned house on the edge of campus on Razorback Road, but in reality, only a small subset of the women who used the Center had anything to do with the University. One woman interviewed by Allyn Lord and Anna Zajicek for their 2000 overview of Fayetteville feminism reminisced of having lived at the Women's Center when she first arrived in Fayetteville intending to "live in the country," with plans to check out the land collectives in the area.[41] The fact that the Women's Center seems to have sometimes extended short-term living space to women totally unconnected with the University is emblematic both of its independence from the University and a wide awareness of the Center as a resource available to all women, a role of which it seems likely the University would not approve. An eventual anti-feminist crackdown on the part of the University of Arkansas motivated by protests from homophobic and anti-abortion student groups eventually led to the closure of the Razorback Road Women's Center in 1980.[42] While it lasted, though, the Women's Center in

[41] Anonymous interview (Interview #021) conducted by Allyn Lord and Anna M. Zajicek. Summarized in Allyn Lord and Anna M. Zajicek, *The History of the Contemporary Grassroots Women's Movement in Northwest Arkansas, 1970–2000* (Fayetteville, AR: No Publisher Listed, 2000). Interview transcriptions in the collection of the author, courtesy Allyn Lord and Anna M. Zajicek.
[42] Lord and Zajicek, p. 39.

Fayetteville represented an unique, uniquely shared, community resource, a vital resource for women seeking community in a small and isolated town like Fayetteville

The sense of community ownership of the Women's Center extended to its constituent organizations. Not atypically for left-leaning and especially feminist organizations of the day, Women's Center groups took the form of collectives that focused on specific projects, all of which appear to have had both University-affiliated members, anchoring them within the scheme of University sponsorship, and members from the wider community. In October 1975, archival documents show that the Center hosted five such collectives, with the most prominent being an active Press Collective that produced Fayetteville's monthly women's liberation newspaper, *Hard Labor*.[43] A women's sports collective facilitated friendly team sports, especially softball, which as Susan Cahn has discussed at length, was a primary locus of women's and lesbian community formation in the 1970s.[44] A "Growth Collective" provided informal personal problem-solving groups in which women could vent their troubles and seek insight and support as they worked to resolve them. A Committee on the Environment engaged in a variety of activities related to environmentalism and environmental protections, a clear overlap with the locally central back-to-the-land ethos.

Last, but certainly not least, there was a Health Collective. This group, which had existed for several years prior to Mari Spehar's death, primarily provided telephone and in-person information and referrals for "problem pregnancy." But it is clear that the Health Collective was aware of, and to some extent linked into, health feminist practices from other parts of the country ranging from feminist women's health to the natural birth movement. They showed films and held classes on

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[43] *Hard Labor* v. 1 n. 4 (October, 1975), p. 10-11. Fayetteville Women's Library Feminist and LGBT Publications Box 2 folder 25, Special Collections, University of Arkansas.

[44] Susan K. Cahn, *Coming on Strong: Gender and Sexuality in Women's Sport,* 2nd edition (Urbana: University of Illinois Press, 2015), p. 185-206.

reproductive health issues including contraception and herbal medicine, provided education about midwifery and homebirth, briefly contributed a women's sexual health column to *Hard Labor*, and now and then offered trainings in "self-help" vaginal and cervical self-examination. This was the group that would, following Mari Spehar's death, metamorphose into the Mari Spehar Health Education Project.

The core members of the Health Collective, including Ginny Masullo (then Ginny Houghton) and Annee Littell, had known Mari Spehar and were shocked and traumatized by her death. In the opening paragraph of the obituary for Spehar that appeared in *Hard Labor,* Masullo wrote: "Would acceptance come easier if Mari, a capable, vigorous carpenter, had fallen off a roof? Her death then being an integral part of her life? Instead, did she die a victim of our decadent technological society? Here is Mari's story, the incidents leading to her death, a tragedy that leaves us with anguished questions yet to be answered."[45] Recreating the Health Collective as the Mari Spehar Health Education Project was their attempt to grapple with their grief for their friend but also their anger at the mainstream health system that had both endangered and failed to save her. The Dalkon Shield, the supreme emblem of the kinds of technologization of everyday life that Mari Spehar had gone to Arkansas to escape, had killed her. Her friends, ever wary of patriarchal control and all the many ways—including medical technologies—in which it infiltrated their lives, experienced Spehar's death as a central consciousness-raising moment that demanded action.

Between the creation of the Mari Spehar Health Education Project and its formal dissolution in 1982, the Project's ambitions swelled and contracted at irregular intervals. At various times, the Project announced intentions to provide an array of services ranging from comprehensive patient advocacy services to cervical cap fittings to opening a full-scale woman-controlled women's health

[45] Ginny Houghton, "The Death of Mari Spehar," *Hard Labor* (March 1977), 4. Fayetteville Women's Library Feminist and LGBT Publications Box 2 folder 25, Special Collections, University of Arkansas.

clinic. Few of these plans, however, ever materialized more than haphazardly and temporarily. The core of its activities remained roughly the same as what had been provided by the Health Collective, right down to the educational sessions on topics like herbal home remedies, the rhythm method, and astrological birth control.[46]

The most consistent of the services provided by the Health Collective and by MSHEP was the Resource Room and Problem Pregnancy Line, which existed from 1977 through 1982. These were effectively the same service and were staffed by the same individuals. The Resource Room was the physical space and its collection of print materials, the Problem Pregnancy Line was the staffer(s) who answered the phone and used collected resources to educate and make referrals by telephone. The Resource Room was initially housed at the campus-affiliated Women's Center as part of the Health Collective. Later on, after the Health Collective had become MSHEP and the University and the Women's Center began to clash over whether the University would continue to support the Women's Center and allot it space, the Resource Room relocated. In its later locations in "The Deep End," a basement space in a large Presbyterian ministry located just off campus, and later in the "Green Warehouse" at the Ozark Co-Op Center, MSHEP's Resource Room furnished a library of print materials on women's health including sexual and reproductive health, contraception, health education and home remedy information, and information about abortion and where abortions could be safely obtained. In archival sources, the Resource Room is sometimes called the "Problem Pregnancy Resource Room," highlighting the overlap of those resources in the eyes of the community and in terms of MSHEP's organizational self-concept.[47]

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[46] "For better or worse," Ginny Masullo reminisced in 2017, "we did a lot of alternative birth control." Masullo interviewed by author, 2017.

[47] See for instance a listing of MSHEP services in *Hard Labor* 5 n. 1 (January/February 1979), 13. Fayetteville Women's Library Feminist and LGBT Publications Box 2 folder 25, Special Collections, University of Arkansas.

The MSHEP's constantly evolving core staff of five to seven women kept the Resource Room staffed when it was open, although hours and availability varied based on the staffers' schedules. Staffers helped visitors find and interpret information, recommended educational resources, and provided references and referrals as they were able. Staffers also provided these services via telephone, a popular service because of its privacy and anonymity. A phone-based women's health information and education service was well suited to an area where the back-to-the-land movement was popular. Women living rurally did not have to sort out the inconvenience and sometimes not inconsiderable expense of traveling from rural homesteads into Fayetteville to obtain needed health information so long as they had access to a telephone.

Little information about the Problem Pregnancy Resource Room's service provision is available. How many women served as MSHEP staffers, training the women may have had, how many referrals they may have made, and what methods they may have used in their interactions with information-seekers were not documented. The lack of documentation of service provided suggests that despite the name change, the efforts remained somewhat ad hoc and there was no sense of an organization attempting to document itself as a corporate entity. Similarly, although documents suggest that at various times MSHEP proposed making an effort to collect feedback from women in the community about their experiences with local health care providers to enable staffers could better provide referrals and references, no such data survives in the archive. It is of course possible, particularly given Fayetteville's small size, that this happened via word of mouth. Either way, the apparent lack of such data collection in any externalized format suggests that the organization's sense of itself and its own needs was shaky at best.

There is much we cannot know, yet a fairly clear outline of the MSHEP's development emerges from the archive. During the first two years, ambitions were understandably high. Galvanized by Spehar's death and aware of the network of women controlled clinics springing up

around the country including regional feminist health efforts that included successful clinics in places like Atlanta and Memphis, MSHEP declared a mission to create a clinic in Fayetteville.[48] Since there were no avowedly feminist or even female physicians in Fayetteville at the time, the need for such a clinic was apparent. Interviewee Carole Cimarron, who worked in the Fayetteville area as a nurse for many years, reported that in the 1980s when physician Janet Titus set up private practice in Winslow, Arkansas, about 22 miles south of Fayetteville at the northwestern corner of the Ozark National Forest, many from the Fayetteville women's community would make the trek just to be able to see a female physician.[49]

With a copy of the Los Angeles Feminist Women's Health Center's handbook *How To Start A Woman-Controlled Abortion Clinic* in hand, MSHEP set about the work of figuring out how to accomplish this goal.[50] Handbook notwithstanding, some of the preliminary steps to clinic formation seem to have eluded MSHEP. Meeting notes betray confusion and suspicion with regard to some of the state prerequisites for opening a clinic, for example establishing and filing a Certificate of Need.

The Certificate of Need is a common legal document that assesses local demographics and available resources in order to determine that a proposed new business, facility, or corporate acquisition is required to fill the needs of the community in which it is to be located. Certificate of Need laws relating to proposed new health care facilities originated in 1964 in New York State and became a national requirement under the Social Security Act of 1972. They were originally intended to function as consumer protection instruments, with the intent that they would help prevent

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48 Anonymous handwritten meeting notes, n.d., Fayetteville Women's Library Collection, Box 26, Folder 26-13, "Self Help Group" University of Arkansas Special Collections.
49 Cimarron interview, 2017.
50 An undated photocopied copy of this handbook exists in the Fayetteville Women's Library Collection, Box 28, Folder 1, "Women's Health Movement." University of Arkansas Special Collections.

inflated health costs resulting from oversaturated markets.[51] Unfamiliar with this common prerequisite and suspecting the worst of this mandatory engagement with the state, the MSHEP staffer who wrote about it in her meeting notes interpreted the Certificate of Need as something that would make MSHEP vulnerable to being "governed and judged by [the] local medical society."[52]

There is no evidence that a Certificate of Need was ever filed by the MSHEP. It is impossible to determine how far along the path toward opening a clinic MSHEP went, or if they did so at all beyond the apparent discussions. Tellingly, when Planned Parenthood decided to open what was then its only Arkansas clinic in Fayetteville in May of 1981, it did so easily on the basis of "need demonstrated by statistics from the West Arkansas Health Systems Agency," one of the regional health service planning and management agencies created in the wake of the 1974 National Health Planning and Resources Act.[53] [54] Planned Parenthood, as a national women's health organization with substantial ongoing state and federal interaction, clearly understood what the state required of it and had no trouble fulfilling those requirements. Clearly they had no difficulties collaborating with the HSA to obtain the data necessary to jump the bureaucratic hoops. One wonders whether the antiestablishmentarian counterculture women of MSHEP would even have known that this shortcut to Certificate of Need data acquisition was an option, or indeed would have considered asking a state agency for assistance at all.

When it came to preparations that did not involve the state, MSHEP did somewhat better. Following the model of many other woman-run feminist health clinics, they developed a close relationship with an established feminist clinic and sent some of their members there as interns to learn by doing how a feminist health clinic was run. This was not the MSHEP's geographically closest option, the Memphis Center for Reproductive Health, but rather the Emma Goldman Clinic in Iowa City. Several core MSHEP members visited the Emma Goldman Clinic in May 1977, with two staffers

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[51] Herbert Harvey Hyman, *Health Planning: A Systematic Approach* second edition, (Rockville, MD: Aspen Systems Corporation, 1982) p. 253. See also Robert Cimasi, *The U.S. Healthcare Certificate of Need Sourcebook* (Washington, D.C.: Beard Books, 2005).

[52] Anonymous handwritten meeting notes, n.d., Fayetteville Women's Library Collection, Box 26, Folder 26-13, "Self Help Group" University of Arkansas Special Collections.

[53] The National Health Planning and Resources Act (Public Law 93-641), January 4, 1975. https://www.govtrack.us/congress/bills/93/s2994/text, accessed April 3, 2017.

[54] Mari Spehar Health Education Project, *The Self Examiner* v. 1 n. 2 (April 23, 1981), n.p., Fayetteville Women's Library Collection, Box 2, Folder 2-7, "Mari Spehar – 1974-1982 – Health Ed Project" University of Arkansas Special Collections.

including founding member Annee Littell returning to stay from September to November, 1977 to gain hands-on experience. Such apprenticeships and clinic visiting for the purpose of skill sharing to allow women to open their own clinics were common within the feminist health movement, and particularly so among the clinics that "radiated out from Los Angeles" as part of the network of clinics associated with the Los Angeles Feminist Women's Health Center. Sandra Morgen discusses this pattern in some detail in *Into Our Own Hands: The Women's Health Movement in the United States.*[55] Participation in this tradition of hands-on learning through extended visits to other clinics thus shows that MSHEP was capable at least of negotiating the highly social requirements of entry of feminist health among feminist health activists.[56]

Upon their return, MSHEP members attended a hospital auction to begin acquiring clinic equipment, and several meetings were held to discuss the clinic and to draft necessary policy. On the issue of whether their hoped-for clinic would become an abortion provider, however, MSHEP's membership was divided. Some members took it as writ that any provider of feminist women's health care should provide abortions, but others disagreed. Some concurred that abortion was an essential service but felt that they would not want to work in a clinic that provided it.

As 1978 wore on, meeting attendance dwindled and meetings themselves were scheduled less frequently. Eventually the goal of opening a clinic was officially put off into the indefinite future, and MSHEP members decided upon patient advocacy and pregnancy testing as the two arenas in which they would focus their attention.[57] The extent to which even these things happened was not extensive. Asked in 2017 whether MSHEP succeeded in creating its proposed patient advocacy program, Ginny Masullo shrugged thoughtfully and recalled having attended "a few" patients as an advocate, but said that this program too had centered around teaching women "how to make a list of questions… how to negotiate the medical encounter" and that it was "all pretty low key."[58] Again, MSHEP appears to have been more a collection of variously feminist and woman-supporting aspirations searching for implementation than it does an organized body seeking to implement a shared body of feminist health belief and practice.

Nevertheless the Mari Spehar Health Education Project managed to become acknowledged to some degree by the national feminist women's health movement. In 1979 MSHEP received a rural women's health organizing grant through the National Women's Health Network that enabled them to pay two regular staffers, but this bounty was not renewable and was thus short-lived.[59] Although this period of time did mark the only period during which the MSHEP had a regular newsletter of its own, *The Self-Examiner*, it does not appear to have otherwise expanded its health activities in the community. By 1982 MSHEP had relocated to the Green Warehouse, and was beginning, albeit perhaps more accidentally than purposefully, to transition into a state in which its reference library was its sole public service. At some point in 1982 (the specific date is unclear)

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55 Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States* (Piscataway, NJ: Rutgers University Press, 2002),100-101.

56 Zeryn Zaire, "The Mari Spehar Health Education Project, Fayetteville, Arkansas" in Dorothy Battenfeld and Elayne Clift, eds., *Patterns for Change: Rural Women Organizing for Health* (Washington, D.C.: National Women's Health Network, 1981), n.p. A photocopy of this publication can be found in Fayetteville Women's Library Collection, Box 28, Folder 26-1, "Women's Health Movement" University of Arkansas Special Collections.

57 Ibid.

58 Masullo interviewed by author, 2017.

59 Zeryn Zaire, "The Mari Spehar Health Education Project, Fayetteville, Arkansas" in Dorothy Battenfeld and Elayne Clift eds., *Patterns for Change: Rural Women Organizing for Health* (Washington, D.C.: National Women's Health Network 1981): n.p.

MSHEP effectively ceased to exist, its Resource Room materials having formed the nucleus for the creation of the Fayetteville Women's Library. The Women's Library, which operated until 1991, was run by a different group of women and had its own mission that was not health focused.[60]

Location, Location, Location

The Mari Spehar Health Education Project's short and uncertain trajectory as a woman-controlled provider of feminist health interventions clearly shows the influences of its location, as well as of a particular group of people passing through a particular moment in cultural and chronological time. Fayetteville's small size and relative geographic isolation within the thickly forested, vertiginous, difficult to navigate Ozarks make its "Southernness" distinctive, proof positive that there are multiple Souths within the region. Fayetteville's specific mix of characteristics—the rurality that made it affordable, the smallness that made it approachable, the isolation that made it compelling to those wanting to escape mainstream culture and urban life, the university that offered certain opportunities and amenities—drew a specific mix of inhabitants. But although Fayetteville was and is a university town, the University of Arkansas was not (and is still not) the only or even the dominant source of political liberalism or progressivism in the locality. We see this in MSHEP's story in several ways, not least of which is the broad orientation of the Women's Center and the central roles played by the Food Co-Op and Green Warehouse.

The feminism that underlay the formation of the Mari Spehar Health Education Project, as we have seen, owed fairly little to academic feminism or to systematic second-wave feminist educational processes like consciousness-raising groups. Nor did it coalesce out of a sensibility of

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[60] Upon its closure, the Women's Library donated its holdings, which included the papers of the Mari Spehar Health Education Project, to the Special Collections of the University of Arkansas Library. These papers represent virtually everything that has been preserved with regard to MSHEP.

traditional medical reform. Rather it was born of the belief that the dominant sociopolitical order was an oppressive one, and that one was better off out of it than in it. This politics of evasion allowed and encouraged a great deal of exploration of alternatives, but did not necessarily predispose to making major commitments to concretely changing extant systems, particularly when so doing would necessitate engagement with the "establishment." It is not a coincidence that "problem pregnancy" educational resources were popular and well-utilized both before and after MSHEP took over the Health Collective, but that when MSHEP members sought to define the parameters of their planned clinic, they found no unity within their ranks on the question of providing abortion care: recognizing that some women wanted and needed access to abortion did not mean that the women of the MSHEP, many of whom were steeped in the pro-natalist culture of the land movement and its back-to-the-land emphasis on midwifery and homebirth, were prepared to provide it.[61] It is similarly not coincidental that engaging with state demands to establish a Certificate of Need proved beyond MSHEP's capabilities, but arranging for visits and months-long internships to other feminist woman-controlled (and thus countercultural and "alternative") health organizations was not.

The Mari Spehar Health Education Project, in other words, was limited by the capacities of its constituency, and its constituency was at least in some important ways determined by its geographic and cultural locations. Whether this is distinctively southern is, of course, debatable: the Ozarks were not the only hotbed of the back-to-the-land movement in the 1970s, and it is possible

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[61] As former resident of Summertown, Tennessee commune "The Farm" noted, the edict in their particular and influential community was "If you're having sex, you're engaged; if you're pregnant, you're married." Gary Rhine, "There Was Great Incentive to Get Married," in Rupert Fike, Ed., *Voices from the Farm: Adventures in Community Living* (Summertown, TN: Book Publishing Company, 1998), 50. See also Pamela Klassen, "Procreating Women and Religion: The politics of Spirituality, Healing, and Childbirth in America" in Linda L. Barnes and Susan Starr Sered, eds. *Religion and Healing in America* (New York: Oxford University Press, 2004), 78-79, 82-84; Jacob Jeffrey, *New Pioneers: The Back-to-the-Land Movement and the Search for a Sustainable Future* (University Park, PA: Pennsylvania State University Press, 1997); Laura Lovett, *Conceiving the Future: Pronatalism, Reproduction, and the Family in the United States, 1890-1938* (Chapel Hill: University of North Carolina Press, 2007), 164-171.

that there are other feminist health stories in some of those localities that would offer parallel examples. Within the South, however, the Ozarks and the Great Smoky Mountains along the Tennessee/Carolina border were the epicenter of back-to-the-land activity. It seems unlikely to be coincidence that the Tennessee mountains furnished the context for the 1970s renaissance in homebirths and lay midwifery, which emerged through the work of a group of back-to-the-landers living at the legendary rural commune known as "The Farm."[62] It also seems unlikely to be coincidence that both in Fayetteville and at The Farm, the feminism of women's healthcare interventions consisted primarily in their principled self-exile from the medical mainstream and their creation of woman-controlled healthcare resources—lay midwifery, natural and herbal contraception—carefully sidestepped the problem of whether to attempt to enter into traditional medical arenas. This was an emotional, a spiritual, and a cultural effort, as suggested by the title of Ina May Gaskin's germinal 1977 lay midwifery book, *Spiritual Midwifery.* Focus on women's health in the sphere of the land movement's influence does not seem to have been a legislative, argumentative, or analytical effort to critique or reform mainstream methods so that they might better include and serve women. Rather, like the land movement itself, women's health efforts that existed in its shadow prioritized resisting becoming part of conventional technologized western civilization.

This combination of strong cultural beliefs and emotions, alongside a weak capacity for analysis and critical engagement, was the MSHEP's perennial Achilles' heel. A generalized belief in women's inherent worth and faith in the power of medical alternatives did not somehow magically create health care that served women or protected them from the faults of mainstream medicine.

[62] Ina May Gaskin, one of the founding members of The Farm in Summertown, Tennessee, created The Farm Midwifery Center, one of the first non-hospital birth centers. Gaskin has been credited (and occasionally blamed) for the emergence and popularization of direct-entry midwifery, that is, becoming a midwife without being trained as a nurse either previously or in addition to midwifery skills.

But neither did the desire to evade overtly harmful mainstream processes and practices automatically generate robust and beneficial alternatives. Despite its principled intentions and best efforts, the Mari Spehar Health Education Project as it existed never approached the organizational coherence or sense of mission exhibited by the other women's health organizations surveyed in this project. In documenting its brief and quixotic lifespan, we see the ways in which both the geographical and cultural locations of its membership combined to place it in a physical location and a cultural moment where a more organizationally and clinically effective mode of health feminism was unlikely to evolve.

Yes, we can say to the young Ginny Masullo, asking plaintively whether acceptance of Mari Spehar's death would've "come easier if Mari, a capable, vigorous carpenter, had fallen off a roof? Her death then being an integral part of her life?"[63] Falling off a roof would have been easily engaged with in the terms of the back-to-the-land counterculture, tragic but innocent of any of the sins of modernity, the kind of accident that could happen a thousand years ago or yesterday. Unfortunately Spehar died, as Masullo suggested, "a victim of… technological society," something for which Fayetteville's particular brand of southern rural counterculture had only avoidant and emotional responses.[64]

[63] Ginny Houghton, "The Death of Mari Spehar," *Hard Labor* (March 1977), 4. Fayetteville Women's Library Feminist and LGBT Publications Box 2 folder 25, Special Collections, University of Arkansas.
[64] Ibid.

Chapter Three

She Did it Her Way:

The Singular Origins of the Memphis Center for Reproductive Health

In late May of 1974, a young, petite, well-educated, socially well-situated white woman named Priscilla Chism opened a for-profit abortion clinic across the street from the Greyhound Bus terminal in Memphis, Tennessee.[1] [2] Newspaper reports reveal that the Memphis Center for Reproductive Health (hereafter MCRH) was initially part of a small group of abortion clinics managed by the Columbus, Ohio, based National Health Care Services, one of the numerous medical management firms to take advantage of the economic opportunities represented by the legalization of abortion following 1973's *Roe v. Wade* decision.[3] From the outset, the clinic had the advantage of the public gravitas as well as the private support of a carefully cultivated social and professional network made up of what Chism later characterized as "very high-caliber, socially established folks" including the chief of the child psychiatry division of University of Tennessee Medical School, staff members in the offices of prominent city officials, local clergy and their wives,

[1] At the time of the research for this project, documents marked as being part of the private collection of the Memphis Center for Reproductive Health were held at and by the MCRH. However, the MCRH has since entered into a relationship with the Sallie Bingham Center for Women's History and Culture at Duke University, and their papers are to be relocated to the Center. Those wishing to consult these papers will want to enquire of the Sallie Bingham Center for further information.

[2] Priscilla Chism, interviewed by Jeff Harris, October 5, 2009. Memphis Center for Reproductive Health History Project files. Private collection, Memphis Center for Reproductive Health.

[3] "Third Clinic for Abortion to Open," *Memphis Press-Scimitar* May 18, 1974. Private collection, Memphis Center for Reproductive Health.

and professors of sociology, psychiatry, and nursing.[4] Chism founded the MCRH with every advantage the granddaughter of the chief of staff of one of Memphis' major hospitals, a native Memphian with over 150 years of Memphis roots on both sides of her family, could bring to the table.[5] Well-versed in the social prerequisites for organizational success in her hometown, Chism created her clinic very much according to a top-down hierarchical model that was, as it was in the case of Planned Parenthood, the National Organization for Women, and other large-group activist organizations in which Chism took part, deliberately and deeply enmeshed in local and regional networks of power.[6] As Chism herself put it in a 2008 email, "MCRH was very much an organization from the outset with staff with strong academic credentials and well respected in society. I'd come from Planned Parenthood, and brought with me a strong base of influence and credibility. I had an attorney for the city of Memphis, psychiatric faculty at UTHSC [University of Tennessee Health Science Center], professor at Memphis State, and others of that caliber on our advisory board…. Heck, we had a Catholic priest on the advisory board, a black father, Brother Ben Boyd."[7]

The MCRH began, in other words, in exactly the ways in which feminist women's health care organizations are, according to both the tenets of feminist activism and the claims of feminist history, *not* supposed to start. As Jan E. Thomas showed in her late 1990s survey of organizational

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[4] Printed copy of private email, Priscilla Chism to Jennifer Marshall (May 28, 2008). Private collection, Memphis Center for Reproductive Health; "News Brief, June 9, 1975," Memphis Center for Reproductive Health. Private collection, Memphis Center for Reproductive Health; Chism interviewed by Harris, 2009

[5] Private collection, Memphis Center for Reproductive Health; "News Brief, June 9, 1975," Memphis Center for Reproductive Health. Private collection, Memphis Center for Reproductive Health; Chism interviewed by Harris, 2009.

[6] Myra Marx Ferree and Patricia Yancey Martin, "Doing the Work of the Movement: Feminist Organizations" in Myra Marx Ferree and Patricia Yancey Martin, eds., *Feminist Organizations: Harvest of the New Women's Movement* (Philadelphia: Temple University Press, 1995), 6-8; Stephanie Gilmore, *Groundswell: Grassroots Feminism in Postwar* America (New York: Routledge, 2013), 12; Stephanie Gilmore, "The Dynamics of Second-Wave Feminist Activism in Memphis, 1971-1982: Rethinking the Liberal/Radical Divide" *NWSA* Journal 15 no. 1 (Spring 2003), 95; Claire Reinelt, "Moving onto the Terrain of the State: The Battered Women's Movement and the Politics of Engagement" in Ferree and Martin, eds., *Feminist Organizations, Harvest of the New Women's Movement* (Philadelphia: Temple University Press, 1995), 84-101;

[7] Priscilla Chism, email to Jennifer Marshall Wednesday May 28, 2008; Private collection, Memphis Center for Reproductive Health.

change within feminist health centers, the comments of other feminist health historians about organizational origin stories generally hold true: feminist health centers tended to come into being as collective projects, put together by groups of women who were drawn to one another through a fairly radical version of feminist thought and activism.[8] This assumption regarding the origins of feminist health centers was already well established by the time of the publication of Sheryl Burt Ruzek's germinal 1978 *The Women's Health Movement*, in which she emphasizes that "some organizations—particularly local clinics or self-help groups—operate collectively" and that such groups are "the health movement's vanguard," in explicit opposition to "reformist" organizations like NOW, Planned Parenthood, or the erstwhile Women's Equity Action League or National Women's Health Coalition which were "accused of not only being reformist but as being a 'front' for the male medical establishment."[9] Of the fourteen women's health centers that had survived into the late 1990s to become part of Thomas's study, ten had begun as collectives, another two with shared directorships, and two with singular directors but very small staffs that shared in both labor and decision-making.[10] These organizational models are reflected in Ruzek's 1978 list of "ideal types of health care worlds."[11] The model of a women's clinic developed and opened by a sole director backed by a largely male board of city and medical authority figures is not one included in Ruzek's influential listing, nor does it feature elsewhere in the extant feminist health historiography.

The current literature also does not offer us another example—although to be sure other such clinics may have existed—of a feminist health clinic being founded using the services of a commercial medical management firm. Commercial management companies were frequently

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[8] See for example Chapter Two of Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick, NJ: Rutgers University Press, 2002), 16-40; as well as Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger Publishers, 1978), 143-171.
[9] Ruzek, 147-148.
[10] Jan E. Thomas, " 'Everything About Us is Feminist': The Significance of Ideology in Organizational Change" *Gender and Society*13 no. 1/2 (February 1999), 104.
[11] Ruzek, 104-124.

involved in the creation of the non-feminist, for-profit abortion clinics that sprang up in the wake of *Roe v. Wade,* examples of what feminist critics sometimes called "entrepreneurial" clinics.[12] Feminist women's health centers were typically financially and administratively independent, conditions made possible through the labor of women who frequently "were regular full-time, from 60 to 80 hours a week" who in some cases earned approval from their colleagues "…by your ability to do whatever it took to get the job done. Putting in as many hours as you could and getting as low a pay as you could."[13] This self-exploitive economic dynamic, conceived as anticapitalist and thus a part of the Marxist or socialist stream of feminism that had emerged from the New Left, was also a common feature of the feminist bookstore movement in which, as the first issue of *Feminist Bookstores Newsletter* proudly announced in 1976, "We want to find ways of dealing with the inherent contradiction between being revolutionaries and being in a capitalist business system." [14][15] While this approach to economics led to some meaningful experiments such as group (rather than private) clinical care and the idea of fee-for-service medical care as a workable path to financing educational and political work, even such an early commenter as Ruzek had to note that "How long women can be induced to work for substandard wages… is impossible to predict."[16] At the same time, though, it was difficult for health feminists to imagine an alternative. Profit was seen as a distinctly unfeminist, and perhaps even predatory, motive for providing medical services to women.[17]

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[12] As indeed National Health Care Services, the management company with which Chism worked in opening the MCRH, did. At the time of the MCRH's opening in May 1974, National Health Care Services had opened clinics in Columbus and Cleveland, Ohio, and Fort Lauderdale, Florida, with plans to open clinics in New Orleans, Louisiana; Oklahoma City, Oklahoma; and Peoria, Illinois. "Third Clinic for Abortion to Open," *Memphis Press-Scimitar* May 18, 1974. Papers of the Memphis Center for Reproductive Health, Memphis, Tennessee. Private Collection.

[13] Thomas, 105.

[14] Barbara Ryan, "Ideological Purity and Feminism: The U.S. Women's Movement from 1966 to 1975" *Gender and Society* 3 no. 2 (June 1989), 243, 252.

[15] Kristen Hogan, The Feminist Bookstore Movement: Lesbian Antiracism and Feminist Accountability (Durham: Duke University Press, 2016), 34.

[16] Ruzek, 172.

[17] Ruzek, 98-102

In light of all this it is particularly noteworthy that within a year after the MCRH was founded, though, its situation as an organization, as well as Chism's situation as an organizer and director, had taken a decided turn to the left. Chism pulled away from the for-profit model, filing for and receiving 501c3 tax-exempt nonprofit status for the MCRH.[18] The MCRH had been able to lower its fees for abortion, despite an expensive move from its downtown location to a big old house on Poplar Avenue in the Midtown district, increasing economic accessibility to services.[19]

Perhaps most interestingly, Chism had become deeply invested in planning, securing Department of Health, Education, and Welfare funding for, and implementing a visionary rape crisis program in conjunction with Memphis Rape Crisis Center and the City of Memphis Police Department. By November 1976, over 300 women would have become recipients of its services.[20] In 1977 the Comprehensive Rape Crisis Program was recognized by the U.S. Department of Justice as one of 23 Exemplary Projects in criminal justice practices.[21] The MCRH continued to succeed as well. As of May 1977, the MCRH was performing about 30 abortions weekly as well as dispensing contraceptive and well-woman care, and had begun to provide a speakers' bureau service, all part of what a *Press-Scimitar* article aptly characterized as a "booming" business.[22]

By the end of 1977, however, Priscilla Chism was gone. Burnt out and frustrated, she left both the MCRH and the Comprehensive Rape Crisis Program behind her as she moved to California to pursue an MBA at Pepperdine University. "I wanted to get out of women's health," Chism would later say. "I wanted to make more money, go in another direction, get out of the

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[18] "News Brief, June 9, 1975," Memphis Center for Reproductive Health. Private collection, Memphis Center for Reproductive Health.
[19] MRCH Scrapbook. Private collection, Memphis Center for Reproductive Health.
[20] "Update: Rape Crisis" MCRH Newsletter, Fall 1976. Private collection, Memphis Center for Reproductive Health; Peggy Burch, "Booming Abortion Business Gets Closer Scrutiny," *Press-Scimitar* March 18, 1977. Private collection, Memphis Center for Reproductive Health.
[21] "Rape Crisis Program Named Exemplary Project," MCRH Newsletter 3 no. 1, May 1977. Private collection, Memphis Center for Reproductive Health.
[22] Peggy Burch, "Booming Abortion Business Gets Closer Scrutiny," *Press-Scimitar* March 18, 1977. Private collection, Memphis Center for Reproductive Health.

nonprofit, and that's what I did."[23] Chism's apparent move to the left, into territory more traditionally associated with feminist and even radical feminist activism and institution-building, seems to have ended as abruptly as it appears to have begun.

This is not the sort of dogged movement commitment, devoid of economic self-interest and replete with self-sacrificial dedication to the cause, the literature both celebrates and tends to presume in both feminist and other forms of progressive activist leadership. As the work of economic sociologist Viviana Zelizer reminds us, we have inherited an old and sturdy concept of "separate worlds" when it comes to the realm of the sacred (or sacralized) and the economic, particularly the capitalist.[24] Whether conceptualized along Biblical lines as the conflict between God and mammon or in Marxist perspective as the profitably reductive commodification of human life, events and acts that seem to challenge the incommensurability of human life and its distinctiveness tend to be viewed not merely with ambivalence but with a queasy, deep sense of offense.[25] This potentially includes many realms of human interaction, but centers particularly on any enterprise that "transgresses," as Laura J. Miller puts it, "the boundary between the incommensurable sacred and the marketable profane."[26] Miller and Zelizer, together, note that not only do person-to-person caregiving, sexual intimacy, spiritual care, healing, and death enter into this category but also things "that are meant to care for the soul, and the spirit, and the mind" like books, art, music, and other pursuits (potentially including political activism) taken up in the name of human flourishing.[27] Among feminists, a consciousness of this tension was evident nowhere so vividly as in feminist

[23] Chism interviewed by Harris, 2009.
[24] Viviana Zelizer, *The Purchase of Intimacy* (Princeton: Princeton University Press, 2005), 23-24.
[25] Viviana Zelizer, *The Purchase of Intimacy* (Princeton: Princeton University Press, 2005), 18-24; Viviana Zelizer, "Human Values and the Market: the Case of Life Insurance and Death in 19th Century America" *American Journal of Sociology* 84 no. 3 (November 1978), 592-593.
[26] Laura J. Miller, *Reluctant Capitalists: Bookselling and the Culture of Consumption* (Chicago: University of Chicago Press, 2006), 19, 217; Zelizer 2005, 14-24.
[27] Ibid.

bookstores, which strove and struggled, as Kristen Hogan succinctly puts it, to "interrupt systems of capital" and in its place develop an "information economy [that] was based not on supply and demand but on building feminist vocabularies."[28] But other feminists, including those less connected to the "radical" arm of feminist organizing where an explicitly Marxist or socialist critique of such economics might be more prevalent, perceived it too. Jo Reger's 2002 study on organizational dynamics in two different city chapters of the National Organization for Women, for example, shows that NOW members in Cleveland, Ohio, viewed women who used their NOW experience as resumé fodder as behaving inappropriately, using NOW as a tool of individual advancement and gain rather than communal betterment.[29]

What, then, can a historian make of Priscilla Chism and the highly unusual origin story of the Memphis Center for Reproductive Health? It might be easy to dismiss Chism, and even the MCRH itself, as a fluke, one of those odd blips that prove that even a stopped clock is right twice a day. The continued success of the MCRH, which continues to provide reproductive health services including abortion forty-five years later, could easily and not without reason be divorced from its difficult-to-reconcile origin story. The credit for its institutional development and survival as a more typically framed feminist health center could simply be handed to the groups of activist women who took over when Chism took off. A story could even be written that encoded a sort of conversion narrative, of a non-feminist woman who stumbled into women's health work for all the wrong profit-motivated reasons, then suddenly saw a feminist light so bright that she was unable to withstand its withering rays and retreated, recidivist, into capitalism's well-upholstered lap.

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[28] Kristen Hogan, The Feminist Bookstore Movement: Lesbian Antiracism and Feminist Accountability (Durham: Duke University Press, 2016), 33.

[29] Jo Reger, "Organizational Dynamics and Construction of Multiple Feminist Identities in the National Organization for Women" *Gender and Society* 16 no. 5 (October 2002), 715-719.

What the evidence supports, however, is still another story: that what Priscilla Chism did in founding the Memphis Center for Reproductive Health, and the manner in which she did it, was indicative of a layer of feminist reality for which the well-reified binaries of received feminist history are simply not an adequate explanatory apparatus. It is further not only possible, but plausible, to connect this to what both lesbian-feminist writer Adrienne Rich and, differently, historian Susan K. Freeman refer to as the "politics of location," in this case Chism's location in 1970s Memphis, a "second city" and civil rights movement landmark tucked well behind what Daneel Buring calls "the Magnolia Curtain."[30]

This interpretation owes direct intellectual debts to several historians whose influence is felt throughout this chapter. Sheryl Ruzek's discussion on "Strains and Contradictions in the Multiple Realities of Reform" in *The Women's Health Movement* alerted me to the fact that 1970s health activists were indeed conscious and aware of feminisms beyond (and between) the poles of revolution and collusion.[31] Meanwhile, works including Sandra Morgen's article "The Dynamics of Cooptation in a Feminist Health Clinic" and Claire Reinelt's "Moving onto the Terrain of the State: The Battered Women's Movement and the Politics of Engagement" helped me to see ways in which feminist organizations' choices to engage (or not) with the state complicated and sometimes subverted their politics.[32] Clare Hemmings' "Telling Feminist Stories," simultaneously pushed me to think about the nuance that is lost and the kyriarchal assumptions that are imposed on feminist and queer histories when we stamp them with binaries.[33] Finally, and emphatically, Stephanie Gilmore's *Groundswell: Grassroots Feminist Activism in Postwar America* provided a beautiful example of scholarship explicitly investigating not just the feminist spaces beyond these binaries but also investigating the specific physical and cultural location of Memphis, Tennessee, in the 1960s and 1970s.[34] Bolstered by these sources and the readings they make possible, I propose that the origin story of the Memphis Center for Reproductive Health helps us not only to understand that there were (après Benita Roth) many possible, and sometimes separate, paths to women-controlled health institution-building, and that these paths may be tied to, if not necessarily distinctive to, their regional contexts.[35]

Who Was Priscilla Chism?

[30] Daneel Buring, *Lesbian and Gay Memphis* (New York: Garland, 1997), 17; Susan K. Freeman, "From the Lesbian Nation to the Cincinnati Lesbian Community: Moving toward a Politics of Location," *Journal of the History of Sexuality* vol. 9, no. 1-2 (2000), 139-140; Adrienne Rich, "Notes on a Politics of Location," *Blood, Bread, and Poetry* (New York: Norton, 1989), 210-231.

[31] Ruzek, 181-208.

[32] Sandra Morgen,"The Dynamics of Cooptation in a Feminist Health Clinic" *Social Science and Medicine* 23 no. 2 (1986), 201-210; Claire Reinelt's "Moving onto the Terrain of the State: The Battered Women's Movement and the Politics of Engagement," in Myra Marx Ferree and Patricia Yancey Martin, eds., *Feminist Organizations: Harvest of the New Women's Movement* (Philadelphia: Temple University Press, 1995), 84-104.

[33] Clare Hemmings, "Telling Feminist Stories" *Feminist Theory* 6 no. 2 (2005), pp. 115-139.

[34] Stephanie Gilmore, Groundswell: Grassroots Feminist Activism in Postwar America (New York: Routledge, 2015).

[35] Benita Roth, Separate Roads to Feminism: Black, Chicana, and White Feminist Movements in America's Second Wave (New York: Cambridge University Press, 2004).

Getting at the question of what it means that Priscilla Chism created the MCRH in the way that she did requires that we understand, at least in broad outlines, who she was. A brief personal history helps us to make sense of Chism not only as a determined solo actor, but also but as a woman whose success in organization-building was situationally and historically dependent on her individual and distinctive contexts and networks of place, race, class, education, and organizational action.

With Memphis ancestry stretching back more than 150 years on both sides of her family, Priscilla Chism's southern bonafides were beyond reproach.[36] She was raised in East Memphis, an area of the city long known for its solidly middle- and upper-class demographics. East Memphis includes several significant local landmarks, including the prestigious Chickasaw Country Club, founded in 1922, and the Memphis Botanic Garden, founded in 1947 on the grounds of a famed local plantation. Fiercely intelligent, Chism attended Memphis' private Rhodes College and later, University of Tennessee—Memphis, where she earned a Masters of Social Work, a field that fitted well with her self-described background as a "middle-class" white woman.[37]

Social work also opened Chism's eyes to social inequities of race and class, an awareness deepened during graduate internships at the Memphis Department of Welfare and a year spent as a psychiatric social worker in the public schools in the then poverty-stricken and majority-Black Boston suburb of Dorchester, Massachusetts. Although Chism had been somewhat aware of race and class differences in her native Memphis, it was her Massachusetts experience which left her "thunderstruck by the disparity of resources" allocated to the poor, mostly-black Dorchester elementary schools in which she worked in 1969.[38]

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[36] Priscilla Chism, interviewed by Jeff Harris 10/5/2009. Memphis Center for Reproductive Health History Project. Private collection, Memphis Center for Reproductive Health.

[37] D. Crystal Coles, F. Ellen Netting, and Mary Katherine O'Connor, "Using Prosopography to Raise the Voices of Those Erased in Social Work History" *Affilia* 33 iss. 1 (2018), 85-97; Leslie Leighninger, "The History of Social Work and Social Welfare" in Catherine N. Dulmus and Karen M. Sowers, eds., *The Profession of Social Work: Guided by History, Led by Evidence* (Hoboken: Wiley, 2012), 1-34.

[38] Chism interviewed by Harris, 2009.

Upon her return to Memphis in 1970, Chism learned from a newspaper article that Memphis Planned Parenthood had received funding for health information projects, and promptly presented herself as the right woman for the job. She was promptly hired and spent the next three years developing an information and education program for the organization. Among Chism's achievements during her tenure at Planned Parenthood was the creation of a speakers' bureau through which the organization was able to reach approximately ten thousand people a year.[39]

But Planned Parenthood was not the only place in which Priscilla Chism built a name and a niche for herself in women's organizations or as an advocate for women's issues, nor was it the only place in which she built her network of friendships, political allies, and professional connections. During the same period that she worked for Planned Parenthood, Chism became politically active in several high-profile women's political organizations. She was a charter member of the Memphis chapter of the National Organization for Women at its founding in 1970. In early 1974 she was voted in as one of several vice presidents for the Tennessee chapter of the National Women's Political Caucus.[40] By the time Chism chose to leave Planned Parenthood in 1973, she had immersed herself for three years in Memphis' women's political organization landscape and become highly visible as a young, energetic, attractive young woman with an impressive résumé and leadership pedigree.

When Chism left Planned Parenthood, she did so in order to go to work as a hospital management consultant alongside African American community leader Harold Whalum.[41] This is noteworthy, because although Chism was sufficiently politically progressive and personally risk-tolerant to be publicly visible as half of an interracial professional partnership, Chism was not a particularly *politicized* being in the sense the historical literature on the women's health movement

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[39] Ibid.
[40] Pat Welch, "Women's Caucus Told Legislature 'A Conspiracy'," *The Tennessean* (April 21, 1974), 2.
[41] Chism interviewed by Harris, 2009.

one might expect from a soon-to-be women's health clinic founder. There is no evidence in Chism's life or career of the sort of New-Left-leaning, consciousness-raising-oriented revolutionary-minded radical feminism made famous in the works of feminists like Jo Freeman, whose 1975 *The Politics of Women's Liberation* both introduced and helped to canonize the notion that there were formal, well-organized "reform," "national" or "large-group" feminists who existed in a certain tension, if not opposition, to "radical," "small-group" feminists.[42]

Freeman's typology characterized the type of older, formal, hierarchically organized national organizations in which Chism participated as policy-oriented, not necessarily connected to (or desiring connection with) a mass movement at the grassroots. The younger, "small-group" feminists, meanwhile, lacked—often quite intentionally—the formality, organization, hierarchy, reach, or policy orientation of the national groups.[43] This difference, also seen in the Civil Rights movement, the source of so much energy and strategy for so-called "second-wave" feminism, can also be conceived in terms of readiness to engage with the state: the more formal organizations are more likely to "co-opt state institutions and use state resources and authority for movement purposes," while those closer to the movement at the level of the people "attempt to play a more direct role in the implementation of change by establishing parallel institutions or intervening more directly in state activities" in order to immediately benefit their constituency.[44] There are clear parallels for feminism, in the form of legislatively active and policy-minded groups like the National Organization for Women as opposed to parallel institution-builder organizations working at the community level like feminist health organizations or the women's bookstore bookstores. Even

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[42] Jo Freeman, The Politics of Women's Liberation: A Case Study of an Emerging Social Movement and its Relation to the Policy Process (New York: Longman, 1975), 49-51

[43] Ibid., 50-51.

[44] Kenneth T. Andrews, "Creating Social Change: Lessons from the Civil Rights Movement," in David S. Meyer, Nancy Whittier, and Belinda Robnett, eds., *Social Movements: Identity, Culture, and the State* (New York: Oxford University Press, 2002), 108.

more pointedly, and more influentially to feminist health, we might similarly consider the Congressional hearings on the safety of the contraceptive pill convened by Senator Gaylord Nelson that were noisily and very publicly gate-crashed, to historic effect, by Alice Wolfson and other members of D.C. Women's Liberation, vigorously insisting that women be invited to the table.

Activists themselves drew lines in the sand with regard to these stylistic and organizational differences. In the introduction to their 1995 *Feminist Organizations: Harvest of the New Women's Movement*, Myra Marx Ferree and Patricia Yancey Martin identify the salient characteristics activists of the 1960s and 1970s identified with their own organizations, which they called "*feminist* organization[s]" (emphasis in the original), apparently to distinguish them from earlier, or simply different, women's organizations like the League of Women Voters or NOW. These included "embracing collectivist decision-making, member empowerment, and a political agenda of ending women's oppression."[45] To be feminist, in other words, is to be defined by individualism: it emphatically involves individual emotional and cultural engagement in the form of "empowerment" and a political or group agenda of ending sex-based oppression (however defined), but explicitly excludes formal hierarchies of power or overt structures within groups. Little wonder that this led to a sense that to be "feminist"—that is, radical rather than reformist—was more authentic, more emotionally genuine, less corrupt (or corruptible), and less beholden to extant power structures. Feminist women readily perceived these differences among themselves and their organizations. One member of the New York City NOW, interviewed by sociologist Jo Reger, reminisced about how this competition manifested in 1970s New York: "You have upper crust ladies' clubs with all the trappings of feminism. You have the National Women's Political Caucus. So even from day one

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[45] Ferree and Martin, 5.

…NOW in this town competed with a variety of other women's groups and so it was always differentiated."[46]

Historian Stephanie Gilmore, who has likewise researched the National Organization for Women as an important site of feminist movement identification and operations, explicitly recognizes that scholars, too, have taken up this binary reform/radical distinction, even despite the fact that "anyone who has been engaged with social movement activism knows that labels rarely apply in a doctrinaire manner."[47] To be sure there are those, like Patricia Yancey Martin and emphatically both Reger and Gilmore, who have long worked to resist this narrative. Even Jo Freeman, who arguably originated the use of the "reformist" and "radical" binary, has gone on the record as saying "the terms 'reformist' and 'radical' by which the two branches are so often designated are convenient and fit into our preconceived notions about the nature of political activity, but they tell us little of relevance."[48]
But such pleas for subtlety or even accuracy have made little difference. The reform/radical rubric emerged from and through women like Jo Freeman and Alice Echols, who were not only scholars of the 1960s-1970s feminist movement but an active part of it, a fact which imparted particular authority to the use of "reform" and "radical" as a presumed distinction between feminist types.[49] It is now casually reiterated in many places, including numerous textbooks such as the 2018 fifth edition of Rosemarie Tong and Tina Fernandes Botts' popular and influential *Feminist Thought: A More Comprehensive Introduction*, whose first chapter is entitled "Liberal Feminism" and second chapter, seemingly inevitably, "Radical Feminism."[50]
One of the several historiographical problems with this is, of course, that it generates considerable observer bias. We find, by and large, the kinds of things we expect to, and it is this that we tend to desire to display as well. Gayatri Spivak reminds us, in *A Critique of Postcolonial Reason* that "the past is a past present—a history that is in some sense a genealogy of the historian," a thing that lets the Western writer present the façade of "disinterested history, even when the critic presumes to touch its unconscious."[51] Part of this, as Clare Hemmings argues, is a matter of "feminist emotion," which is "central to the feminist stories we tell, and the way that we tell them. Challenges to these stories, from within as well as outside feminism, are frequently experienced and responded to at an emotional level."[52] Our political emotions show both in our tendencies to uncritically romanticize those on the (in this case feminist) barricades and our impulses to vilify those in positions of (presumably patriarchal) power. Our emotions, as well as our training to elide our historian-selves so that we are as invisible as possible in the historiography, may also mean that we become considerably less likely to notice, or to include, those who do not easily fit into the meaning-making schemes we have inherited. This was particularly the case for European and European-descended male historians, who embodied the saying "write what you know": until the second half of the 20th century, Great White Man history was not only the dominant but also often the only historiography available on a topic. It is arguable that this is one major reason that Southern organizations have gotten short shrift in the extant historiography on the feminist movement. As this project demonstrates, southern institution-makers and institutions do not always fit comfortably into the accepted narratives made from observations of other women in other, more Northern and coastal, places, by women who were themselves largely from those places. Fish don't see the water they swim in.

[46] Jo Reger, "More Than One Feminism: Organizational Structure and the Construction of Collective Identity" in David S. Meyer, Nancy Whittier, and Belinda Robnett, eds., *Social Movements: Identity, Culture, and the State* (New York: Oxford University Press, 2002), 174.
[47] Gilmore, 13.
[48] Freeman, 50.
[49] Alice Echols, *Daring to be Bad*: *Radical Feminism in America, 1965-1975* (Minneapolis: University of Minnesota Press, 1989).
[50] Rosemarie Tong and Tina Fernandes Botts, *Feminist Thought: A More Comprehensive Introduction*, Fifth Edition, (New York: Westview Press, 2018).
[51] Gayatri Spivak, A Critique of Postcolonial Reason: Toward a History of the Vanishing Present (Cambridge: Harvard University Press, 1999), 207-208.
[52] Hemmings, 120.

This is a problem we confront when thinking about Priscilla Chism not only as a southerner but also as a feminist. Although her engagement in NOW, founding of the MCRH, and other activities would suggest a strong feminist commitment, by the time of a 2009 oral history review she described her feminism as a component of functional egalitarian humanism.[53] This is simultaneously consonant with expressions of a "Golden Rule" basis to feminism Nancy Whittier discovered to be frequently expressed by self-identified "radical" feminists as they aged into the Reagan era, and consonant with a nearly apolitically broad, and thus culturally palatable commonly-claimed American sense of beneficent equality that might be associated with virtually any progressive or reform-oriented effort.[54]

It is not difficult to imagine Chism in her role performing broad-based outreach for Planned Parenthood in 1970 using this stance to present the promotion and provision of contraception as a generally humanist endeavor. This approach was perfectly in line with post-WWII constructions of contraception as part of a wholesome, prudent approach to "family planning." This approach was, and still is, Planned Parenthood's bread and butter and it had been so, plus or minus some inconsistently held eugenics agendas, since the early twentieth century. Chism's stance on feminism, so far as we know it, does not mesh at all with the kinds of feminisms espoused by other feminist clinic founders, particularly in the northeast and the California coast. As historians, then, we must ask: should Chism be considered a *feminist* health activist? Or merely an investor in *women's* health?

Organized Women in/and the Southern States

To answer this question, we must look carefully at Chism's embeddedness in conventionally structured, hierarchical, often long-lived organizations that were deeply rooted in an American

[53] Chism interviewed by Harris, 2009.
[54] Nancy Whittier, *Feminist Generations: The Persistence of the Radical Women's Movement* (Philadelphia: Temple University Press, 1995), 94-95.

historical continuity of progressive political and social justice work. Planned Parenthood, of course, dates from Margaret Sanger's controversial efforts in early twentieth-century New York City; the National Women's Political Caucus, founded in 1971, was explicitly spurred by the ongoing failure to pass the Equal Rights Amendment, first drafted in 1923 in the wake of the successful passage of the 19th Amendment in 1920.[55] [56] The National Organization for Women, founded in 1966 in the wake of unsuccessful federal negotiations over including sex discrimination under the aegis of the Equal Employment Opportunity Commission (EEOC) as an implementation of Title VII of the Civil Rights Act of 1964, partook therefore not only of the politics of earlier rounds of women's rights agitation but more importantly of a long trajectory of racial equality activism beginning with Reconstruction and continuing through the midcentury Civil Rights movement.[57] These organizations were propelled and invigorated, to be sure, by the energy and the momentum of the winds of societal change that swept the American 1960s. But they were in many ways institutions that channeled the continuity of women's organized struggle, not departures from it.

Nor did they wish to be seen that way. Demonstrable continuity, in the eyes of at least some feminists, bred legitimacy. This was the era in which the agendas of a politically motivated recuperative women's history altered the historical discipline by showcasing a range of previously mothballed distaff pasts, and as Nancy Hewitt's renowned essay "From Seneca Falls to Suffrage? Reimagining a "Master" Narrative in U.S. Women's History" puts it, "revealed the multifaceted movements that constituted woman's rights campaigns in the nineteenth and early twentieth

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[55] Joyce Berkman, "The Question of Margaret Sanger" *History Compass* 9 no. 6 (2011), 474-484; Planned Parenthood Federation of America, "Our History," https://www.plannedparenthood.org/about-us/who-we-are/our-history, accessed 30 May 2018.
[56] National Women's Political Caucus, "NWPC History," http://www.nwpc.org/history/, accessed 30 May 2018.
[57] National Association for Women, "Founding," https://now.org/about/history/founding-2/, accessed 30 May 2018; Gilmore, 21-28.

century."[58] Hearkening back to the "Declaration of Rights and Sentiments" compiled at Seneca Falls in 1848 (which NOW did particularly explicitly, compiling its own modern version in 1998), name-checking the suffragists, and pointedly recalling Abigail Adams' 1776 "remember the ladies" letter to husband John, these organizations made their bid to be recognized as just another part of America's fine old laudable and eminently understandable heritage of those seeking access to their (supposedly) inalienable rights to "life, liberty, and the pursuit of happiness."

Such organizations, whether or not they labeled themselves as "feminist" or as involved in any way in a "women's rights" framework, had been a means for women to organize to do philanthropic, political, and social progress work since the nineteenth centuries. Many of these organizations, as well as other superficially non-feminist groups like the Catholic Worker movement, provided contexts in which women could work together on issues overwhelmingly affecting women, like poverty or child health and welfare.[59] In *Survival in the Doldrums: The American Women's Rights Movement, 1945 to the 1960s,* a work that gives the lie to the common misconception of a women's movement that lay down and died after the 19th amendment and was resurrected more or less singlehandedly by Betty Friedan in 1963, Verta Taylor and Leila J. Rupp discuss the many ways in which a mostly quiet, certainly "elite-sustained" (as Rupp and Taylor put it) women's organizational and political landscape kept the fires of the "woman movement" banked but alive during the post-WWII period when it seemed least present.[60] Women's clubs and organizations, which allowed especially white, middle-class or elite women simultaneously to "maintain their place" socially and culturally while also connecting and working with other women, have been an American mainstay

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[58] Nancy Hewitt, "From Seneca Falls to Suffrage? Reimagining a 'Master' Narrative in U.S. Women's History" in Nancy Hewitt, ed., *No Permanent Waves: Recasting Histories of U.S. Feminism* (New Brunswick, NJ: Rutgers University Press, 2010), 15.

[59] Nancy A. Naples, Grassroots Warriors: Activist Mothering, Community Work, and the War on Poverty (New York: Routledge, 1998), 88.

[60] Leila J. Rupp and Verta Taylor, *Survival in the Doldrums: The American Women's Rights Movement, 1945 to the 1960s* (New York: Oxford University Press, 1987), 4-8, 46-50.

since the nineteenth century and have been of particular importance to women in smaller cities and towns, as well as in more sociopolitically conservative areas.[61] Taylor and Rupp present a table of women's organizations they perceive as contributing to the survival of suffrage-era "woman's movement" thought pre-1945 that includes four "core" groups such as the National Women's Party and the Business and Professional Women's Clubs and nine major "peripheral" groups including the General Federation of Women's Clubs, the American Association of University Women, Zonta, Soroptimist, and the National Association of Colored Women.[62]

Because women's organizations were key to carrying on the tradition of women's networking and community action in the "doldrums" between suffrage and the 1960s, it is particularly important to consider the ways this happened in the South, where scholars like Anne Firor Scott, Karen Cox, Caroline Janney, and Joan Marie Johnson have shown a particularly deep, cultural resonant, and in many ways distinct women's organizational tradition.[63] A thumbnail sketch of this history helps to demonstrate how and why. These clubs and organizations, in the South, grew up in the aftermath of the Civil War, as early as May 1865 in some of the cases Caroline Janney discusses. This places them several decades after the rise of similar organizations in the North.[64] In the midst of the South's devastated post-war economy, social structures, and cultural identity, southern white women (and here I will speak only white women; black women's organizational lives also blossomed at this time but were fundamentally different) seized upon the possibility of creating

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[61] Joan Marie Johnson, *Southern Ladies, New Women: Race, Region, and Clubwomen in South Carolina, 1890-1930* (Gainesville: University Press of Florida, 2004), 4-5.
[62] Rupp and Taylor, 46.
[63] Karen Cox, Dixie's Daughters: The United Daughters of the Confederacy and the Preservation of Confederate Culture (Gainesville, FL: University Press of Florida, 2003); Caroline Janney, Burying the Dead but Not the Past; Ladies' Memorial Associations and the Lost Cause (Chapel Hill: University of North Carolina Press, 2008); Joan Marie Johnson, Southern Ladies, New Women: Race, Region, and Clubwomen in South Carolina, 1890-1930 (Gainesville: University Press of Florida, 2004); Anne Firor Scott, The Southern Lady: From Pedestal to Politics, 1830-1930 (Charlottesville, VA: University Press of Virginia, 1995); Anne Firor Scott, Natural Allies: Women's Associations in American History (Urbana: University of Illinois Press, 1991).
[64] Janney, 4.

their own organizations in the name of church outreach, community benefit, and cultural reclamation. Beginning with "church circles," which concentrated on missionary aid especially to those beggared by the war, and "memorial societies" that specialized in collecting, burying, and memorializing the Confederate war dead, these women's organizations swiftly became a backbone of both individual and cultural recuperation efforts.[65]

White women's organizations, particularly those involved in the creation and maintenance of Confederate cemeteries and other memorializations, swiftly became the standard-bearers of what became known as the "Lost Cause" narrative and generating and transmitting a vindicating, idyllic, righteous vision of what Karen Cox has named "Confederate culture."[66] These women's activities, much like those of their Northern sisters, were typically viewed as extensions of their caretaking roles as mothers, wives, and daughters, and therefore as inherently apolitical, oriented as they were around sentiment and succor.[67] This created a climate in which southern women's organizations could easily be seen as not only culturally affirming—and thus affirming in specific of the racist, sexist, southern patriarchy that affirmed its own dynamics of dominance by putting its elite white women on the proverbial pedestal—but also, and importantly, as politically safe. These were not organizations that were going to incite unpleasant changes. In these organizations, southern white women could band together, work together, network together, and it was precisely in keeping with what they were "supposed to do" as southern ladies, keeping company with other southern ladies within an expanded domestic circle, doing good works well away from the dirty, public, male realms of commerce and politics.

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[65] Cox, 1-5 and 8-12; Janney, 4-8; Johnson, 1-7.

[66] Cox, 1-2; Janney, 1-3; Johnson, 1-5.

[67] The second chapter of Cox's *Dixie's Daughters* has a particularly good discussion of the emotional and symbolic resonance of women taking up the cause of organizing to care for the wounded culture and identity of the South in the wake of the war, emblematized in the chapter's frontispiece quote from Mary H. Southworth Kimbrough's poem, "Woman's Part in War": "Who bears the long suspense of war?... / When from the bloody battlefield they bring / Them home? And who must comfort, who restore / Men's shattered hopes – who must extract the sting / When victory has passed them by? …We know / Whose task this is …. It has been woman's part in war."

The work these organizations did was, of course, profoundly political. The most prominent example is the enormous role that women's organizations played in manufacturing and materializing the Lost Cause mythos. This work reverberates to this day in every debate over whether another Confederate statue ought to be removed, every journalistic take on the National Memorial for Peace and Justice (also known as the National Lynching Memorial), and every inquiry into the ethics of plantation tourism.[68] Yet many of us also, whether we are ourselves southern or northern, still tend reflexively to see women's clubs and organizations as superficial and social, perhaps benevolent and helpful but definitely auxillary. Among other things, and despite many internal changes in such organizations since the 1950s, the formality and venerability of the words "clubwoman" or "women's organization member" suggest a woman who need not work for a living, which was and remains a marker of a privileged, most likely white and heterosexually married, woman benefiting from the stereotypical political economics of patriarchy.[69] This is true despite the fact that many such women worked (and still work) very hard within their organizations, a fact borne out by the way in which so many of the efforts put forth by such organizations later became ones carried out by the paid, and still overwhelmingly female, social workers and outreach staff of nonprofit organizations.[70]

Indeed, the crossover between the "woman's organization" and the cause-oriented nonprofit organization is and has been substantial. Historian Sandra Morgen has viewed this as a sign of cooptation in the context of women's health, but her assumptions bear inspection. Morgen

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[68] There is a growing scholarship on the relationships between southeastern U.S. mythology/iconography and tourism, cultural voyeurism, racism (and the elision of racism) and spectacle. See for example Reiko Hillyer, *Designing Dixie: Tourism, Memory, and Urban Space in the New* South (Charlottesville: University of Virginia Press, 2014); Rebecca Cawood McIntyre, *Souvenirs of the Old South: Northern Tourism and Southern Mythology* (Gainesville: University Press of Florida, 2011); and Tara McPherson, *Reconstructing Dixie: Race, Gender, and Nostalgia in the Imagined South* (Durham: Duke University Press, 2003).

[69] A. Lanethea Mathews-Gardner, "The Political Development of Female Civic Engagement in Postwar America" *Politics & Gender* 1 Issue 4 (December 2005), 547-575.

[70] See e.g. Daniel Walkowitz, *Working with Class: Social Workers and the Politics of Middle-Class Identity* (Chapel Hill: University of North Carolina Press, 1999), 24-46, 103-126,

proceeds from the standpoint that a version of women's health centered in the ethos of self-help clinic (cervical self-exam) and prioritizing women's experience as a source of knowledge is the *echt* raw and true feminist health, while any version that does not engage in routines of "embodied feminism" such as feminist health conferences, consciousness-raising, and political activism represents a compromised version at best. Morgen also valorizes deprofessionalization, and presumes that professionalization diminishes the benificent influences of feminist politicization.[71] These assumptions valorize a particular model of creation of health organizations—a model that is consistent with the northern and coastal histories that form the bulk of the historiography—at the expense of being able to see the ways in which the creation of feminist health organizations could be considered one of many distinctive manifestations of a long-lived political continuum of women's progressive institution-building.

When we recall that Priscilla Chism was trained as a social worker, and that it was upon her return to Memphis following a year working in Boston city schools that she seized the chance to take up a community outreach position within the Memphis chapter of Planned Parenthood, this becomes all the more significant. Planned Parenthood, whose national organization as well as chapters were typically helmed by women, was certainly more overtly political than the Junior League. But its reliance on social workers and community educators to help transmit a family planning agenda and bring contraceptive counseling and contraceptives themselves to the widest possible general public, very much including the working-class and poor, was also an identifiably reformist agenda. A spiritual descendant of the proto-feminist nineteenth-century "voluntary motherhood" movement, as well eugenics agendas and socioeconomic arguments, Planned Parenthood's purpose historically was (and remains) the reproductive caretaking of the general

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[71] Sandra Morgen, "The Dynamics of Cooptation in a Feminist Health Clinic" *Social Science and Medicine* 23 no. 2 (1986), 203-207.

public, and specifically women who might become the mothers of children. Thus, although from the viewpoint of sociocultural conservatism Planned Parenthood was less "safe" than, let's say, the Soroptimists, it was by no means a nest of revolutionaries.

Underscoring its organizational and cultural palatability, Planned Parenthood was also in something of a boom era at the time Priscilla Chism joined it. In 1970, the Title X Family Planning Program was created as part of the federal Public Health Service Act. A minimum of 90 percent of its budget must be used for provision of family planning and associated reproductive health services, which by the terms of the law are prioritized for use by low-income Americans.[72] Eight years later, Title X would be amended to emphasize accessibility of reproductive health and fertility control services to adolescents.[73] The history behind this legislation may be traced back not only to Eisenhower-era concerns about overpopulation and the post-WWII baby boom, but as far back as Title V of the Social Security Act of 1935, which authorized the creation of Maternal and Child Health programs. The economic and health issues raised by high birthrates, large family sizes, and low income were officially part of the federal agenda. The first federal grants earmarked specifically for fertility-control based family planning arrived in 1964, as part of the Johnson adminstration's War on Poverty, and the move proved sufficiently popular that Nixon subsequently developed an interest in it as well, becoming the legislative godfather of the Title X Family Planning Program.[74]

By 1970, in other words, organizations receiving the new Title X funds would be seen as participating in civic-minded, responsible, entirely respectable public health work. In those halcyon pre-Hyde Amendment, pre-Operation Rescue days before the polarizing politicization of abortion services, Planned Parenthood appeared in many ways not so different from other women's

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[72] Institute of Medicine, A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results (Washington, D.C.: The National Academies Press, 2009) 1-5, 35-44.
[73] Ibid., 5.
[74] Ibid., 43-44.

organizations striving to improve child nutrition or teach home economics to poor mothers. Priscilla Chism's role in public relations with Memphis Planned Parenthood circa 1970-1973 would have amounted to raising awareness for and about this worthy cause.

When encountered in the archival record as the founder of the Memphis Center for Reproductive health, Chism's reality is exactly this. As a middle-class white college-educated daughter of a well-established family, she lived the life of a respectable industrious, dedicated southern lady whose efforts were duly focused exactly where they should, socially speaking, have been. She was a social worker active in women's organizations. The fact that those organizations, Planned Parenthood, the National Organization for Women, and the National Women's Political Caucus had women's autonomy of various kinds as their goals was perhaps less important than that they were women's organizations, and thus viewed tacitly—and superficially—as both culturally safe and socially supportive within the cultural rubric of the south. The feminism of these organizations and the women who participated in them could, in short, be at least nominally acceptable in a way that louder, more individualistic, more intensively politicized feminism never could.

The fact that women's organizations belonged to women helped to camouflage their politics. They were feminine and thus trivial. It is noteworthy that this has parallels in the symbolic feminization of the U.S. south as a whole as a conquered agricultural region of "moonlight and magnolias" and old-fashioned, backward ideas and values, much less important than the masculine, forward-thinking, innovative powerhouses of the conquering industrial north.[75] Thinking about these two things side by side provides some insight into why some manifestations of southern feminism can be, from the standpoint of traditional feminist historiography, difficult to see and parse. Some southern feminisms manifested well to the right of the political location at which the

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[75] James C. Cobb, *Away Down South: A History of Southern Identity* (New York: Oxford University Press, 2005) 144-146; Tara McPherson, *Reconstructing Dixie: Race, Gender, and Nostalgia in the Imagined South* (Durham: Duke University Press, 2003), 19.

northern and coastally-based movement understood itself to exist. If one imagines this northern/coastal political location as integral, or indeed coextensive with, "the feminist movement," then there are manifestations of feminism that literally fall off the map.

And so when we find an enterprising and ambitious woman emerging from a background of privilege, education, and thorough enmeshment in traditional hierarchical women's organizations doing something that the literature leads us to believe was generally done only by overtly feminist groups, it makes sense, given the northern and coastal biases of the historiography, that we might wonder whether what she was doing was feminist at all. Upon further reflection, however, this curiosity might invert itself. In a part of the country known for its sociopolitical conservatism, might not an approach like Chism's have been the least obstacle-strewn path by which a feminist health organization might come to life? The founding of MCRH was decidedly not the "sisters are doing it for themselves" cooperative shoestring affair so often showcased in the literature. Chism partnered with Marvin Ratner, a Memphis lawyer and friend of Chism's lawyer husband, to open a for-profit abortion clinic testifies to that. Chism began the MCRH as its "counselor and manager," according to news reports, not as "founder" or "director," and operations management was supplied by a third-party commercial medical operations firm.[76] On the surface level of newspaper clippings, MCRH looked a lot like any other for-profit abortion clinic at the time of its founding.

But such a reading does not help to explain the forty-plus year survival of MCRH as an avowedly feminist women's health center. Chism's deep roots in the Memphis community, and in longstanding, culturally well-integrated communities of politically active women, do. These factors also, as we will see, allow us to better understand one of Chism's major contributions via the

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[76] "Third Clinic for Abortion to Open," *Press-Scimitar*, May 18, 1974, n.p. Private collection, Memphis Center for Reproductive Health.

MCRH, namely, her work in helping to create a Comprehensive Rape Crisis Program at the city level in Memphis.

Working for Women in "The Rape Capital of the Nation"

Memphis in the early 1970s had a reputation as a dangerous place for women. During 1973, according to FBI statistics, 534 rapes were reported, their victims ranging in age from toddlers to octogenarians. Given that according to the FBI, only about 10% of rapes were actually reported, there may have been well over five thousand rapes in Memphis that year. Little wonder that the city was known, at least regionally, as "the rape capital of the nation."[77]

Little wonder, either, that Memphis women were fed up and began, in a concerted way, to alert the broader community to the problem. As Stephanie Gilmore documents in her monograph *Groundswell*, Memphis NOW (of which Priscilla Chism was a charter member) took a leading role in this activism, decrying in particular the exceptionally low indictment rate on reported rapes of only 14% and, among that 14%, an execrably low conviction rate of 19%. If we take as our point of departure the 534 reported rapes in 1973, this means that only 75 of these reported rapes resulted in an indictment and 14 resulted in a conviction. Framing the issue as one of protection and safety for women, NOW women engaged in a number of awareness and activist campaigns, of which the most visible was a street action in which they picketed around the perimeter of Overton Park, site of a widely-known gang rape.[78]

In this way, NOW women neatly demonstrated their own ability to bridge modalities of feminist effort as well as directions of thinking about the safety of women and the sources of that safety. As a boots-on-the-ground visibility action, the Overton Park protest clearly owed a debt to

[77] Gilmore, 59.
[78] Ibid., 59-60.

the street protests of the Civil Rights era, to which Memphis was no stranger, as well as those of some of the more "radical" components of Women's Liberation elsewhere, for example the infamous 1968 protests against the Miss America pageant. But the words of other NOW members, such as officer Marion Keisker, signified a somewhat different approach to thinking about rape and responsibility for stopping it. Keisker's statement that "Women are only as safe as civilized man allows" hearkened, in its use of the words "civilized man," to a notion of white heterosexual male "civilization" particularly redolent in a region with a particular and violent racially charged history around rape.[79] The evident mixture of these ideas and approaches within NOW, as Stephanie Gilmore successfully argues, demonstrates their coexistence within the organization and its members and the way in which NOW, as an organization, resists classification in binaristic liberal/radical, grassroots/national, and direct action/legislative historiographical heuristics.[80]

Priscilla Chism's personal role in Memphis' anti-rape and rape crisis work, as I believe the record handily displays, not only underscores Gilmore's perceptions about Memphis NOW but deepens it considerably by demonstrating that a formal, state-linked, and indeed governmentally funded feminist direct action program was developed in a way that showed no evident notice of, and indeed would've been considered unimaginable in the political rhetorics of, the self-identified "radical" feminisms of the time.

As Chism later recalled, this episode of her and the MCRH's history began in 1975 in relation to her participation in NOW, where she first became aware of the extent and implications of Memphis' rape problem.[81] NOW efforts such as the Overton Park protest quickly motivated the Memphis Police Department to form a Sex Crimes Squad, a unit it had not previously included, and

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[79] Gilmore, 60. In regard to the dialectic of white heterosexual cis-male "civilization" see e.g. Gail Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States* (Chicago: University of Chicago Press, 1995)
[80] Gilmore, 60-61.
[81] Chism interviewed by Harris, 2009.

to begin creating what was known as the "Comprehensive Rape Crisis System."[82] The thinness of the written archive provides few chronological landmarks from which to recreate a calendar of events, but by November 1976, the Comprehensive Rape Crisis System had provided medical help to over 300 women, and Priscilla Chism and the MCRH were an integral part of the services provided.[83]

As Chism recounted, NOW had brought her into contact with Brenda Brown, a Memphis Police Department planner. Brown's tales of the callous and dismissive treatment rape victims received at public hospitals outraged Chism, who realized that since the injuries sustained by most rape victims did not require the medical or surgical resources of a hospital, there was no reason they could not be physically examined (and forensically if desired) in some other more supportive, less frightening environment such as the MCRH. Although Brown and Chism wrestled somewhat over the focus of this project and whether it ought to be more oriented toward the collection of forensic evidence or the provision of health care and counseling services, they rapidly wrote a grant. Chism then used her well-cultivated connections to pull in the support of Memphis Mayor Wyeth Chandler, Chief of Police Gen. Jay Hubbard, and Tennessee Senator Howard Baker (later Senate Majority Leader and Chief of Staff under Ronald Reagan), who helped the grant through the federal funding process. Though Chism had hoped for more distinctively health-related funding that would encourage seeing the program as centrally about women's health, the money ultimately came through the Department of Health, Education, and Welfare, and was administered by the police department. All medical and counseling services, however, were provided in the Poplar Street offices of the MCRH.[84]

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[82] Gilmore, 60.
[83] MCRH Newsletter, Fall 1976. Private collection of Choices Memphis Center for Reproductive Health.
[84] Chism interviewed by Harris, 2009.

The medical arm of the Comprehensive Rape Crisis System, as Chism implemented it, was a massive departure from typical in-hospital forensic exams of the era in which both evidence and women themselves were treated at best cavalierly, and without standard procedures or evidence collection protocols. Although some hospitals had begun on their own initiatives in the 1950s to collect forms of forensic evidence from the bodies of women who had been raped, it remained an uncommon and idiosyncratic practice. Martha Goddard, who at the time was working to help develop what would become the now-standard Sexual Assault Evidence Kit (SAEK), recalls going to the Chicago Police Department in the early 1970s and asking what sort of forensic evidence was gathered, only to be told "Mart, we don't get evidence. Sometimes people try and they take two slides with swabs from say the vagina or the mouth and or the rectum. They put it on the slides. They make the slides. They rubber band 'em together in there face to face. So there goes that. It's worthless. It's just absolutely worthless. We don't get hair. We don't get fingernail scrapings. We don't--nothing's marked to tell you what's vagina and what is the rectum. We don't get decent clothing evidence."[85] At times, after having been required to submit their clothing as evidence, women who had just undergone post-rape examinations were sent home via police car wearing nothing but a hospital gown.[86]

As biomedical advances rendered biomedical evidence more useful, however, and as women and feminists began to bring the magnitude of sexual assault to the fore, activists and law enforcement professionals began to work, both together and separately, to create better and more functional alternatives to such scenarios. One of them was the SAEK, which was known as the "Vitullo kit" after its 1978 debut after Chicago Police sergeant and microanalyst Louis Vitullo, who

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[85] Marty Goddard interviewed by Anne Seymour, February 2003. History of the Crime Victim Assistance Field Video and Audio Archive, University of Akron. http://vroh.uakron.edu/transcripts/Goddard.php
[86] Ibid.

developed and standardized it.[87] Another, developing roughly simultaneously, was Chism's model, in which a team of nurses with masters' degrees and specialized training in gathering forensic evidence and another team of trained peer counselors were on call 'round the clock to come to the clinic when needed. These advocates, called Sexual Assault Nurse Examiners (SANE), collected evidence, provided counseling, dispensed prophylaxis for pregnancy and sexually transmitted infection, and could also give expert testimony in court if desired. Chism worked with Dr. Beverly Bounds, a University of Tennessee nursing professor and one of her personal contacts, to create the model and gain access to the nurse clinicians in question; the SANE model remains an important element of rape crisis work today.[88] Volunteer peer counselors were recruited from among the MCRH staff and supporters, as in the Fall 1976 issue of the MCRH newsletter, which noted that at the time of publication, 16 such volunteers were already trained and on call.[89]

There were significant differences of opinion between Chism and the Police Department about how the program should be administered. Chism, for instance, took a broadly feminist women's health oriented approach, demanding that these medical and counseling services to be available on demand for any woman who had been raped, whether she reported the rape to the police or not. The Police Department, on the other hand, was administering the DHEW grant money, and they determined that the services should be limited to women who had reported their rapes to the police.[90] Other differences of opinion also arose. Chism, for example, wanted to emphasize the role of the SANE and of trained volunteer counselors to use only counselors from

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[87] Betty Freudenheim, "Chicago Hospitals Are Using New Kit to Help Rape Victims Collect Evidence," *New York Times* (December 2, 1978) https://nyti.ms/1LYAUXL. Accessed June 11, 2018; Jessica Ravitz, "The Story Behind the First Rape Kit" *CNN.com* (November 21, 2015) https://www.cnn.com/2015/11/20/health/rape-kit-history/index.html Accessed June 11, 2018.

[88] Chism interviewed by Harris, 2009.

[89] Newsletter, Memphis Center for Reproductive Health (Fall, 1976). Private collection of Choices Memphis Center for Reproductive Health.

[90] Chism interviewed by Harris, 2009.

and trained through the MCRH. She took great umbrage at being forced to accept some differently-oriented, differently trained counselors from the city's crime victim assistance program as well.[91] While Chism perceived that things had gone smoothly in the beginning of her involvement with the Comprehensive Rape Crisis Center, the situation deteriorated as some of her collaborators—first her police-based program administrator, Brenda Brown, then Dr. Beverly Bounds, and finally Chief of Police Jay Hubbard—left their jobs and, in some cases, left Memphis entirely. Describing it in a 2008 e-mail, Chism wrote,

> "The collaboration with the Memphis Police Department on what was then called the Rape Crisis Center became increasingly nightmarish. Just imagine what the technicolor account would be. It began as a collaboration with Gen. Jay Hubbard, head of the MPD, Brenda Brown, the MPD planner who did the study on sexual assault and teamed up with me in writing the proposal (my part was the medical/psych part), and Dr. Bev Bounds (Nurse Ph.D.), head of the nurse clinician program at UTCHS [University of Tennessee Health Science Center]. By the time we got midway through… I was the only one still in Memphis, trying to slay all the dragons essentially by myself with the base of MCRH and the cadre of powerful allies I'd developed. It was so bizarre, the only ones who wanted to shoot it down were the NOW folks. AMAZINGLY bizarre. It got a lot worse."[92]

Despite all this, Chism's part of the Comprehensive Rape Crisis System was not just novel, it was effective. The number of rape prosecutions dismissed for insufficient evidence dropped by 60% within a year of the start of the program. This was sufficiently noteworthy in the annals of law enforcement that in May 1977, Chism was chosen by the U.S. Department of Justice as an innovator of a "Exemplary Project" in justice and law enforcement, invited by the Department of Justice to take part in a two year long program in advanced criminal justice practices, to travel to other communities to help teach her model to other communities, and to help the Department of Justice

[91] Ibid.
[92] Priscilla Chism, email to Jennifer Marshall, dated Wednesday, May 28, 2008. Private collection of Choices Memphis Center for Reproductive Health. All emphases in the original.

develop a brochure and a program manual to help others follow the Memphis model.[93] She would never do any of those things. Instead, she left the Comprehensive Rape Crisis Program to those who seemed to want to run it and the MCRH to its core of staffers and moved to Malibu.

In this series of events, as may already be quite evident, Chism was at the center of the collision of multiple organizational and political categories often depicted, by the extant feminist health movement literature, to be reasonably distinct. Working as the sole proprietor and manager of the MCRH, but simultaneously as a well-connected Memphian with years of experience connecting the community's political elite and its intellectual and medical movers and shakers, she had her hand firmly on the rudder of developing a large and important victim assistance program—and every intention of keeping it there. At the same time, her activity grew from the same general bed of what Stephanie Gilmore describes as an extensive NOW involvement in rape crisis work: NOW established the city's first rape crisis hotline and staffed it with volunteers from their ranks, while President Julia Howell was appointed by Mayor Chandler to serve as the director of Memphis' first municipal Rape Crisis Program.[94] The papers of the MCRH do not offer any insight into whatever conflicts there might have been between Chism's involvement with rape crisis work and NOW's activity, but judging from Chism's 2008 email we may assume that such conflicts existed.

Ought this to be interpreted as textbook conflict between an individual and aggressive activist (Chism) and a large-group, by necessity slower-moving, organization (Memphis NOW)? Chism's eagerness to work in an aggressive, institution-building, grant-seeking way with agents of the state, at least up to a certain point, makes it impossible to simply say yes, as does Chism's reluctance to allow the state to join with or intervene in those aspects of the project she clearly saw as hers. While Chism's involvement with the state in the Comprehensive Rape Crisis Program

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[93] Newsletter, Memphis Center for Reproductive Health vol. 3 no. 3 (May 1977). Private collection of Choices Memphis Center for Reproductive Health.
[94] Gilmore, 60.

certainly demonstrates some of the ways that, as Sandra Morgen so effectively argues, dependency on external funding constrains the political autonomy of women's health centers (and other organizations), it remains the case that with regard to the rape crisis work, Chism does not seem to have dreamt of doing it any other way.[95] This was not a self-determined, self-directed "by women, for women" program that later resorted to state funding to sustain itself. Willingness to be funded by, and to work hand in hand with, government at all levels in order to achieve goals important to the government was integral to program development.

It is not possible to look at Chism's efforts with the Comprehensive Rape Crisis Program—to improve the physical and psychological care of women who had been sexually assaulted in order to improve their quality of recovery and improve the quality of evidence-gathering in order to improve the quality of prosecution—and construe them as "unfeminist." Given Chism's emphasis that the services be provided by women nurse examiners and women volunteer counselors in a women-run, women-staffed environment, it would be difficult even to construe them as opposing the goals or methods of the feminist health movement writ large. But it is also not possible to easily describe exactly what kind of feminism this might be, or succinctly characterize the mode or model of feminism by which it was enacted. Historiographical and in-movement assumptions about what feminist organization and activism "should be" do not readily apply.

Just as with the founding of the MCRH itself a year prior, this was Priscilla Chism's idiosyncratic feminism in action. Chism clearly did not subscribe to any definition of feminism sufficiently doctrinaire to constrain her from being who and what she was as a southern woman who unapologetically and without restraint used the full potential of the regional and local networks of power and hierarchy in which she had very intentionally embedded herself, devoid of any evident

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[95] Sandra Morgen, "The Dynamics of Cooptation in a Feminist Health Clinic" *Social Science and Medicine* vol. 23, no. 2 (1986) 201, 205.

feeling that she "should have been" doing it in any other way. As we will see, Chism's iconoclastic feminism not only extended to embracing the state—at least until she got frustrated with it—and likewise extended to embracing some far more traditional and typical elements of the feminist health movement, ones that ultimately carried the MCRH into the next phase of its existence.

A Big Tent

Not all of the women who became involved with the MCRH, including its Rape Crisis arm, shared Chism's unusual politics or approaches. Among the MCRH papers there is evidence of another population of Memphis health feminists, far more typical of historiographic expectations yet all but archivally and organizationally invisible until after Chism's departure. These were women who had become politicized around feminist women's health via consciousness-raising groups, through reading *Our Bodies, Our Selves*, or, as in the case of Carrie Roberto, who would later become Director of the MCRH for a time in the later 1970s and 1980s, by aborting an unwanted pregnancy at MCRH.[96] Some of these women became staffers at the MCRH, and it was they who stepped in to take over MCRH when Chism left. What their presence demonstrates, via archival evidence of feminist self-help group meetings, participation in a women's health collective, and the practice of menstrual extractions, is that even as Priscilla Chism was engaging in women's health as a well-connected Memphian lady unbeholden to anyone else's version of what women's health activism should look like, that there was in fact another stream of health feminism active in Memphis. More interestingly, and contributing to our understanding of Priscilla Chism as a women's health activist without any particular stakes in movement feminism, these more "typically radical" health feminists operated within, not merely under the umbrella of, the MCRH.

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[96] Bernice Stengle, "Abortion Clinic Director Relishes Ongoing Battle for Women's Rights" *The Commercial Appeal* (January 1980), 22.

Most obvious, in terms of its archival traces, was the self-help group. Several flyers attest to its existence and its evening meetings at the MCRH, but MCRH institutional brochures of the time do not make mention of it as an official offering. This omission, in light of the way MCRH's organizational brochures listed the availability of both a speakers' bureau and women's self-defense classes as part of their services, seems telling.[97] The self-help sessions, described on a flyer as "Women sharing experiences and knowledge on a variety of gynecological topics: natural methods of birth control, techniques of *self*-pelvic examination, pelvic infections-natural cures, history of gynecology in U.S., abortion, breast cancer, prepared childbirth, and more!" reads very like other descriptions of self-help sessions common during the period. Influenced heavily by then-current trends in feminist activity such as recuperating and learning history of women's medicine, self-knowledge and self-care, and of course the invocation of "natural" (as opposed to the "artifice" of technological biomedicine) methods and cures, it shows that these feminist health activists were conversant with the issues and tactics of the movement as they had begun to be communicated nationally through books like *Our Bodies, Our Selves* and the famed national self-help tour undertaken by Los Angeles Feminist Women's Health Center founders Lorraine Rothman and Carol Downer. Despite the fact that the MCRH had not been organized with this model or this ideological world in mind, it was clearly welcome beneath MCRH's Poplar Avenue roof.

Over time, according to former MCRH staffer and board member Judy Card, some of the self-help group members formed the Memphis Self-Help Collective.[98] This mobile crew of women attended "women's fairs and women's groups and we would demonstrate how to do self-health exams. We made and gave out free plastic speculums and we made a slideshow of our cervixes

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[97] "Memphis Center for Reproductive Health Welcome…" brochure, (n.d., circa 1975), Private Collection, Memphis Center for Reproductive Health; "What Is 'Self-Help'?" flyer, (n.d., circa 1976), Private Collection, Memphis Center for Reproductive Health.
[98] Judy Card interviewed by Sarai Chisala, October 19, 2009. Private Collection, Choices Memphis Center for Reproductive Health.

which we would show."[99] The distribution of speculums and the self-exam slideshow were activities pioneered by Downer and Rothman during their national tour, and taken up by many of the self-help groups that formed in their wake. It is unknown whether Priscilla Chism ever took part in self-help, let alone participated in the activities of the Collective. It is clear that self-help was not for her the entrée into women's health activity that it was for many women of the era. In interviews, Chism does not mention self-help, and states that she cannot remember what the Collective was, so it seems likely that she thought it peripheral at best to her operation.[100] Yet the MCRH sponsored the Memphis Self-Help Collective and furnished its base of operations, so it would be impossible to argue that Chism simply did not know about the model or the method and had not been exposed to the ideology of women's self-help healthcare.

There are many questions we might ask about Chism's relationship to self-help and to the stream of health feminism that took self-help as its foundational practice. It is useful to wonder, for instance, whether Chism's independence, which would seem to fit well with this stream of health feminism's push for deprofessionalization and the prioritization of women's own knowledge, could coexist with Chism's canny cultural-capitalist alliances with experts and authorities. The archive does not tell us. But the archive does suggest that Chism, perhaps along with her staff at MCRH, was not resistant to deploying at least one medically radical technique that came out of the self-help stream of feminist women's health. So far as this author is aware, the MCRH was one of a very few women-controlled health clinics in the country that offered menstrual extraction as a purchasable service, and in so doing, a clinic that put a public price tag on a procedure that was otherwise done only among members of a dedicated feminist health underground.[101]

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[99] Card interviewed by Chisala, 2009.
[100] Chism interviewed by Harris, 2009.
[101] Newsletter, Memphis Center for Reproductive Health vol. 2 no. 2 (April 1976), n.p. (3). Private Collection, Memphis Center for Reproductive Health.

Functionally speaking, menstrual extraction is very similar to uterine aspiration, the most common and popular technique for early-term abortion. An extremely narrow flexible plastic cannula is introduced into the uterus through the cervical os—in this case undilated, because of the small size of the cannula and the largely liquid nature of the contents to be aspirated—and a large syringe or other hand-operated suction mechanism is used to gently suction out the uterine contents. The procedure ordinarily takes three to five minutes, has few common side effects aside from possible menstrual-like uterine cramping, and has a very low rate of complications. Devised by Southern California feminist health activist Lorraine Rothman in 1971, it was initially intended as a way for women to control menstruation by simply extracting the uterine contents all at once rather than endure multiple days of menstrual flow and all its concomitant unpleasantries.[102] Rothman invented a gentle DIY suction device, the Del-Em (DELete Menstruation) that sported a one way valve to eliminate the possibility of an accidental air embolism. Women learned about the procedure and the device by word-of-mouth, including through in-group-only workshops taught to self-helper women by other self-helper women. By 1974 it had become sufficiently popular, and a sufficient topic of conversation among at least West Coast feminist health self-helpers, that the Oakland Feminist Women's Health Center convened a conference to discuss it. In the proceedings of this conference, it is made amply clear that self-helpers considered menstrual extraction's appropriate context to be within menstrual-extraction self-help groups only, where it would be mutually performed and received by all members. Two speakers at the conference, Shelley Farber and Laura Brown, savagely criticized public health agencies' and male doctors' attempts to co-opt the technique for non-feminist and especially profit-making reasons. "It is not a service that is performed on a

[102] Lorraine Rothman, opening speech transcript, *The Proceedings of the Menstrual Extraction Conference* (Oakland, CA: Oakland Feminist Women's Health Center, 1974), 12. Fayetteville Women's Library Collection, University of Arkansas Special Collections.

woman," Shelly Farber stated, "but something that is done in a group where a woman having her period removed is the most important part of that group."[103]

It is, therefore, odd to find menstrual extraction listed as exactly that—a service—in the April 1976 MCRH newsletter. A contemporaneous listing of clinic services with prices puts the menstrual extraction at the same price as an early suction abortion (up to 12 weeks), with which is it not incongruent.[104] The newsletter's brief description of menstrual extraction, in fact, makes it clear that at MCRH it was being performed not instead of early abortion, but *as* a form of early abortion: a positive pregnancy test was required. While little or no uterine swelling was another prerequisite for menstrual extraction, this does not alter the fact that these "menstrual extractions" were performed to extract more than merely menstrual uterine contents. Another way to think of menstrual extraction as it was offered by the MCRH, is as an extremely early term, physically lower-impact suction abortion. It was of course always possible that a menstrual extraction, performed in ignorance of a conception, could for all intents and purposes constitute an abortion. It is not out of the realm of consideration that in some self-help groups, this was openly acknowledged and possibly used in an opportunistic way. Publicly, however, menstrual extraction proponents neither focused on this prodromal possibility or suggested that it be exploited.

It is at present unclear whether the MCRH was the only women-run clinic to offer menstrual extraction as a service. (A reference to the Vermont Women's Health Center's statistics on the procedure (reporting a 2% failure rate as a means of pregnancy termination) may indicate that the Vermont WHC also performed the procedure in clinic, but as of this writing this can be neither

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103 Shelly Farber, opening speech transcript, *The Proceedings of the Menstrual Extraction Conference* (Oakland, CA: Oakland Feminist Women's Health Center, 1974), 18. Fayetteville Women's Library Collection, University of Arkansas Special Collections.

104 Newsletter, Memphis Center for Reproductive Health vol. 2 no. 2 (April 1976), n.p. (3, last page). Private Collection, Memphis Center for Reproductive Health.

confirmed or denied.[105]) The MCRH is, however, clearly anomalous in its having done so. Offering menstrual extraction as a service, whether unique to the MCRH or not, raises still more issues about the nature of Priscilla Chism's approach to feminist health, particularly her sense of herself as a part of a wider movement to whose ideals and priorities she and the MCRH might be beholden. The existence of the self-help group and the later collective show Chism's clear feelings that self-help-oriented feminist health had some place within MCRH. But the commercialization and the functional reorientation of menstrual extraction simultaneously show a clear willingness to engage in exactly the economic exploitation and the goal appropriation that the self-help-based menstrual extraction community railed against. Chism, it would appear, either did not know that the menstrual extraction community would disapprove of such a thing, did not agree, or simply did not care. Menstrual extraction appears to have been taken up as another tool for the MCRH toolbox, as useful as other tools Chism used to make the organization successful like institutional hierarchies, recognized relationships with local and regional power brokers, and federal funding.

It seems possible that a similar pragmatism may have motivated the MCRH's shift, during its first year, to 501c3 nonprofit status. While many feminist women's health organizations explicitly eschewed profit as their motive, operating as worker-owned or worker-run collectives and deliberately setting fees as low as they could reasonably afford, Chism had begun MCRH, as previously discussed, on a for-profit model. There is no archival record of the switch to nonprofit status in the papers of the MCRH, and so it is difficult to guess what Chism intended; her only surviving comment is that "I felt it should be non-profit and I took it over and established it as a 501c3."[106] However, given the cultural and emotional tensions between intimate personal

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[105] Newsletter, Memphis Center for Reproductive Health vol. 2 no. 2 (April 1976), n.p. (3). Private Collection, Memphis Center for Reproductive Health.

[106] Chism interviewed by Harris, 2009.

interventions and profit-making (see the discussion earlier in this chapter), organizations that statutorily do not make a profit are likely to be perceived as being more trustworthy, their motivations in providing services rather than generating profit. As a Planned Parenthood veteran, Chism would also not have been unaware of the ways in which funding opportunities might be enhanced by tax-exempt nonprofit status. Chism did not, evidently, see it as contradictory to her goals to be running a women's health clinic on a for-profit basis. Nevertheless, when she felt this should change, it did. That it changed to be more in line with typical feminist health organization practices regarding corporate profit may appear, superficially, to bring Chism and the MCRH closer in line with the practices of other more historiographically typical women's health organizations, but there is no guarantee that this was an issue that registered, let alone mattered.

She Did It Her Way

Taken together, what we are left with in considering Priscilla Chism, her founding of the Memphis Center for Reproductive Health, and her innovative work in establishing the medical side of Memphis' Comprehensive Rape Crisis System is the picture of an ambitious, ferociously intelligent, driven young Southern woman whose canny understanding of her local political and social environment joined her innate pragmatism in pursuit of women's health in a way that far outstripped any given political leaning or doctrine. The scope of her efforts shows a woman whose feminist vision—regardless of what she may have called it—had both reach and resonance. The reality of her efforts shows a woman whose single-minded willingness to create programs that worked let her pour herself, body and soul, education and connections, into doing so without feeling obligated to embody or enact any particular political or social outcomes beyond the programs themselves. They also show a highly successful young woman unprepared for what happened when she suddenly found herself without the support that had allowed her to be so successful. Her

attempt to singlehandedly drive the legendarily balky oxen of the state proved (as ever) reliably exhausting. Without the experience or tools to negotiate this and unwilling to continue to throw her own energies at something she could not budge, she walked away.

Chism's life, shaped as it was by the metalanguage of how her white skin, middle-class privilege and education, organizational connections, and lengthy family history in Memphis produced a person perhaps uniquely outfitted to do the work that she did in a city historian Keith Wailoo refers to as "known for economic and racial conservatism" and its self-definition as a cosmopolitan place that stood out and away from its impoverished rural Delta geographic surroundings.[107] Priscilla Chism, it seems, knew which bits of the envelope she could push—become an abortion provider, create services for rape victims—and which to leave alone. She likewise knew that who she was, and her extensive organizational life, would cause her to be read as a certain kind of appropriately volunteerist, rather than perhaps crassly careerist, southern woman, well versed in local women's social hierarchies and histories of public power. She did not appear to be one of those urban, coastal, northern young people looking to overthrow The Establishment. In fact, she seemed positively to revel in working with well-established doctors, lawyers, professors, and politicians, using their influence to increase her own. It was a performance of a kind, a particularly adroit navigation of the expectations of her class and race and region in the name of creating things that she felt were needed, useful, and humane. It was exceptionally effective, allowing her to do a great many things in a very short three year span.

What it was not then, and is not today, is easily parsed using the tools feminism has supplied for its own historical self-analysis. Removed, both geographically and philosophically, from hotbeds of cutting-edge feminist movement activity, Chism does not seem to have been tempted to join in.

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[107] Keith Wailoo, Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health (Chapel Hill: The University of North Carolina Press, 2001), 10-11.

Perhaps this was principled refusal, perhaps it was simple lack of interest in the political stringencies, moral purity politics, and doctrine wars of the feminist early 1970s, but the result was the same. She did not embody any model or faction completely, nor did she refuse any on principle. That this seems so odd, and so noteworthy, is partly a consequence of the illusory tidiness of activist hindsight and scholarly analysis.[108] But it is also odd and noteworthy because it *was* remarkably unorthodox, a wholesale and perhaps even opportunistic willingness to instrumentalize whatever methods and techniques seemed most productive.

Benita Roth has famously written of women's "separate roads to feminism," their individual and at times collective paths only rarely fitting well into scholarship's pigeonholes.[109] But in Priscilla Chism's case, she was not on a road to feminism—feminism was not her destination, nor did it remain her motivation in later chapters of her life in which she became, variously, a grad student earning an MBA, a young expatriate living with her husband and infant in Saudi Arabia and, much later, a successful specialty job recruiter within the medical industry. She described herself as a feminist only insofar as she described herself as a humanist.[110] And yet she labored for three intense years doing the hard, much-needed, deeply feminist work of creating women-controlled, women-staffed health resources for other women, in the process creating an organization that was not only capable of surviving the loss of its founder but transitioned into a more typically and recognizably "feminist health center" in the process. It remains difficult, from the perspective of feminist and feminist health historiography, to explain Priscilla Chism's feminist health work in terms that make it easy to place in the larger trajectory of the movement, and perhaps that is only fitting. The founding of the MCRH was exactly how it wasn't supposed to be, and yet the organization worked and

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108 Gilmore, 13-16.
109 Benita Roth, Separate Roads to Feminism: Black, Chicana, and White Feminist Movements in America's Second Wave (New York: Cambridge University Press, 2003).
110 Chism interviewed by Harris, 2009.

continues, 45 years later, to work as intended, providing abortion and other reproductive health services to any and all who ask for them in Memphis, Tennessee.

Chapter Four

Sisterhood, Self-Help, and Strife: the Making and Unmaking of the National Black Women's Health Project

The National Black Women's Health Project was emphatically born and raised in the South. The deliberate choice on the part of National Black Women's Health Project (hereafter NBWHP) founder Byllye Avery to locate her nascent organization in Atlanta placed it on a stage deliberately chosen to take advantage of Atlanta's status as the "black Mecca" and its long history as a hub of Black progressive intellectual and cultural activity.[1,2] The earliest appearance of what would eventually become the NBWHP took place in and around Gainesville, Florida, in 1980-1981. In 1990 the NBWHP would set up offices in Washington, D.C., the start of a process of abandoning its identity as the core of a pervasive national network of grassroots city- and state-level Black women's health organizations and assuming an inside-the-Beltway presence focused on lobbying, legislation, and the creation of knowledge and policy on Black women's health. In between, it was based in

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[1] As Harlem had been earlier in the century, by the early 1970s Atlanta had widely been anointed as the "Black Mecca" in the African-American press. See e.g. Phyl Garland, "Atlanta: Black Mecca of the South," *Ebony* XXVI no 10 (August 1971), 152-157. For a latter-day consideration of this nickname and status, see Robert D. Bullard, Glenn S. Johnson, and Angel O. Torres, "Atlanta: A Black Mecca?" in *The Black Metropolis in the Twenty-First Century: Race, Power, and the Politics of Place,* ed. Robert Bullard (New York: Rowman and Littlefield, Inc. 2007), 162-183. Additionally, since the 1890s, when Atlanta University began to serve as the home base for W.E.B. DuBois' endeavors, Atlanta has been a hub of Black intellectual progressivism, a legacy that continues to be honored by academic organizations that choose the city preferentially for conferences on African-American issues, e.g. the Southern Anthropological Society, which chose it as the site of its Key Symposium in 1990 and explained its reasons for doing so in the introduction to Hans A. Baer and Yvonne Jones, eds., *African Americans in the South: Issues of Race, Class, and Gender,* Southern Anthropological Society Proceedings 25, (Athens: University of Georgia Press, 1990), 2.

[2] Loretta Ross, one-time National Program Director for the NBWHP and lifelong women's health advocate, concurred in a November, 2016 interview, cited the "Black mecca" phenomenon and the abundance of Black colleges and universities in Atlanta as among the reasons Atlanta was a logical place for Byllye Avery to start the NBWHP. Loretta Ross interviewed by author, November 8, 2016.

Atlanta, forging a nationwide web of chapters focused around the signature offering of the NBWHP, its distinctive model of Self-Help consciousness-raising, support, and politicization. In 1996 its Atlanta "mother house" closed its doors permanently, leaving the D.C. group, now known as the National Black Women's Health Imperative, as its sole public-facing manifestation.[3]

The transformations of the 1990s, however, would not have been possible without the deliberate move from Gainesville to Atlanta that permitted the NBWHP to establish itself firmly in the landscape of what Carol Wiseman characterizes as the "women's health megamovement."[4] It was in Atlanta that the NBWHP forged its Self-Help methodology, spread its influence nationwide, and created its first and only clinical offshoot, the community-level Center for Black Women's Wellness.[5] Atlanta was, in Avery's own terms, the place and the context where "a special magic at a special time" could take place. Atlanta would ultimately also provide the backdrop for the NBWHP's near-demise as a clash of loyalties, methodological priorities, and institutional orientations divided women who had long worked as devoted sisters in the cause of Black women's health.[6] As the southern Black metropolis nonpareil, Atlanta enabled the NBWHP to coalesce and grow in its initial manifestations, the innovative and culture-shifting period that provided impetus for numerous other women of color health organizations.[7] It is not coincidental that as the dust settled from the dramatic internal schisms and reorganizations of the late 1980s and early 1990s, the

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[3] Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutierrez, *Undivided Rights: Women of Color Organize for Reproductive Justice* (Chicago: Haymarket Press, 2016), 86.

[4] Carol Weisman, *Women's Health Care: Activist Traditions and Institutional Change* (Baltimore: Johns Hopkins University Press, 1998), 37-93. Weisman devotes a chapter to characterizing this "megamovement" from its nineteenth-century origins to the late 20th century.

[5] At least one state chapter of the NBWHP also formed a community-level clinical presence. In 1994, a "self-help wellness center" called The Well was established in a low-income housing project in southeast Los Angeles by the California Black Women's Health Project (CBWHP), the state-level coordinating group of the NBWHP. See Karin A. Elliott Brown, Frances Jemmott, Holly J. Mitchell, and Mary Walton, "The Well: A Neighborhood-based Health Promotion Model for Black Women," *Health & Social Work* 23 no. 2 (May 1998), 146.

[6] Byllye Y. Avery interviewed by Loretta Ross, July 21-22, 2006. Voices of Feminism Oral History Project (Sophia Smith Collection, Smith College, 2006), 40.

[7] Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutierrez, *Undivided Rights: Women of Color Organize for Reproductive Justice* (Chicago: Haymarket Press, 2016), 80.

NBWHP ultimately changed location as well as direction, leaving the South behind it as it aligned itself with a policy-based federal orientation toward changing the face of Black women's health care.

Discovering the Limitations of White Feminist Health

The origins of the National Black Women's Health Project are intertwined with the racial-political awakening of its founder, Byllye Avery. Born in 1937 in Waynesville, Georgia and raised in DeLand, Florida, Avery was of an age to have taken an active part in the civil rights struggles of the 1950s and 1960s, and was certainly aware of them, but Avery was a then college student and then a young wife and mother, and she did not become politicized in that context.[8] Avery would later would say that her husband's untimely death at 33 of a heart attack provided an impetus for her to begin thinking about health outcomes and prevention in Black communities, but her road into women's health and specifically Black women's health also had a more direct and, in second wave feminist terms, stereotypical path.[9] In several writings and interviews, Avery discusses this path, revealing that she came to political consciousness much as many white women of her generation did, in the context of becoming informed about shifting abortion laws and in consciousness-raising groups convened and populated primarily by white women.[10] [11]

The story of Avery's politicization as a feminist health activist begins in 1971, when Avery's employers at Shand's Teaching Hospital in Gainesville assigned Avery, alongside two coworkers, Margaret Parrish and Judy Levy, to develop a presentation on the current state of reproductive

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8 Byllye Y. Avery interviewed by Loretta Ross, 8-9.
9 Byllye Y. Avery interviewed by Loretta Ross, 12.
10 Byllye Y. Avery, "Breathing Life Into Ourselves: The Evolution of the National Black Women's Health Project" in Evelyn C. White, ed. *The Black Women's Health Book: Speaking for Ourselves* (Seattle: Seal Press, 1990), 4; Byllye Avery, "A Question of Survival / A Conspiracy of Silence: Abortion and Black Women's Health" in *From Abortion to Reproductive Freedom: Transforming a Movement,* ed. Marlene Gerber Fried (Boston: South End Press, 1990); Byllye Y. Avery interviewed by Loretta Ross, 15.
11 Voichita Nachescu, "Becoming The Feminist Subject: Consciousness-Raising Groups in Second Wave Feminism" (Ph.D. diss., State University of New York at Buffalo, 2006), 1-2. See also Anita Shreve, *Women Together, Women Alone: The Legacy of the Consciousness-Raising Movement* (New York: Viking, 1989).

rights. A presentation of this kind, in the shifting landscape of the pre-*Roe* years, was both an ideological and practical task, encompassing as it did a variety of recent and pending legislation that had legalized contraception (*Griswold v. Connecticut* had been decided 1965, *Eisenstadt v. Baird* would be decided in 1972) and was fast changing the terms on which abortion could be received in a variety of states. Abortion had first become decriminalized in some contexts in Colorado in 1967, followed in short order by California, Oregon, and North Carolina. Hawaii legalized abortion on request in 1970, and in the same year, New York legalized it to 24 weeks. Between 1970 and 1973, twenty states would legalize abortion under at least some circumstances, creating a continuous current of fertility control discourse and controversy. Politicians and public figures including congressional representative and groundbreaking 1972 Presidential hopeful Shirley Chisholm openly supported national legalization.[12] Above-ground services such as the Clergy Consultation Service, founded by the Reverend Howard Moody of Judson Memorial Church, New York City, provided compassionate and nonjudgmental referrals for abortion care. There was, in short, far more to know about than there had been even five years previously, and the political and social climate around women's reproductive autonomy was decidedly shifting in favor of legalization and liberalization.[13]

It comes as no surprise, in hindsight, that Avery and her colleagues had no sooner completed this presentation than they became viewed as experts on the issue in their community, women who could facilitate Gainesville women's access to abortions. Most of the women who contacted them, Avery recalled in a 2006 interview conducted under the auspices of the Voices of Feminism Oral History Project for the Sophia Smith Collection at Smith College, were white. Most of the time, Avery, Parrish, and Levy were able to put these women in touch with the Clergy

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[12] Shirley Chisholm, *Unbought and Unbossed* (New York: Houghton Mifflin, Inc., 1970), 113-122.
[13] Ricki Solinger, *Pregnancy and Power: A Short History of Reproductive Politics in America* (New York: New York University Press, 2005), 178-186.

Consultation Service. When a Black woman called, however, things were different. "…[W]e tried to give her the phone number and she said she didn't need no telephone number in New York," Avery recounted. "She didn't know nobody in New York. She didn't have no way to get to New York, you know. She didn't have no money for New York and all."[14] The caller died soon after of complications of a self-induced abortion, forcing Avery to the realization that limited legalization did not generate equal access, and that when poverty was a factor in legal access to abortion, poverty was also a factor in risk and death.[15]

It was in these moments, as well as in the consciousness raising sessions that Avery began to participate in along with Levy, Parrish, and other Gainesville women, that Avery began to become politicized as a feminist and explicitly as a health feminist. Prior to his death, Avery's husband had tried to convince her to read the newly published *The Feminine Mystique*, thinking she would find it important; ultimately she agreed after reading and discussing it as so many other burgeoning middle-class feminists of her era did, in the context of her consciousness-raising group, surrounded by her white colleagues and friends. Like many other second wave feminists, Avery was primarily politicized around a kitchen table, talking, sharing, and wondering whether change were possible and what could be done to make it happen.[16]

It was around these same kitchen tables that the next chapter in Avery's personal, professional, and political life took shape. As numerous other similar groups did across the country in the wake of the passage of *Roe v. Wade* in 1973, a group including Avery, Judy Levy, Margaret Parrish, Joan Edelson, and Betsy Randall-David took it upon themselves to create a clinic for woman-controlled abortion and reproductive health in Gainesville.[17] The Gainesville Women's

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[14] Byllye Avery interviewed by Loretta Ross, 15.
[15] Ibid.
[16] Ibid., 15-16.
[17] Betsy Randall-David interviewed by author, November 1, 2016; see also Silliman et al., 70; Avery interviewed by Ross, 16.

Health Center opened in 1974, becoming part of the broadening network connected to Carol Downer and Lorraine Rothman's southern California-based Feminist Women's Health Centers. It was an immediate success, but a success in which racial stratification manifested almost immediately in terms of clientele and their uses of the facility. The clinic offered abortion and contraceptives care as well as "well-woman" general gynecological care. While both Black and white women came to the clinic for abortion care, Black women did not come in for the other services despite a variety of attempts on the part of the clinic to reach out to and welcome Gainesville's Black women.[18]

Avery struggled with this discrepancy throughout her time at Gainesville Women's Health Center, happy to be providing important services to the community but unable to figure out how to draw more Black women to the Center. Her attendance at the first National Conference on Women and Health, organized by the Boston Women's Health Book Collective in 1975, did not help her find a solution but did expose her to the newly formed National Women's Health Network, whose Board of Directors she promptly—and, it would prove, fatefully—joined.[19] As the Gainesville Women's Health Center continued its work in 1976 and 1977, clients began to hear about the natural childbirth movement and started requesting birth-related services such as midwifery recommendations. As time went on, the Health Center also began to experience dramatic conflicts stemming from personality clashes, differences in political priorities, and correspondingly divergent and divisive methods of administrative control.[20] These ultimately led to a schism in which Avery and Margaret Parrish, along with the woman at the core of many Health Center conflicts, the notoriously prickly and brusque Judy Levy, left the Health Center to form BirthPlace, which at the

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[18] Avery interviewed by Ross, 17; Avery (1990), 85.
[19] Silliman et al., 70; Avery interviewed by Ross, 18-19.
[20] Randall-David interview.

time of its opening in 1979 was one of only a handful of freestanding alternative birthing centers in the country.[21] [22]

Aware of the long tradition of African-American midwifery in the South, Avery was hopeful that celebrating this lineage would draw Black women to the midwifery options available at BirthPlace in ways they had not been drawn to the full breadth of care available at the Health Center.[23] [24] This too proved elusive. The reasons proved to be both economic and cultural. As part of ongoing campaigns to wipe out lay midwifery in favor of hospital births, state and federal health programs routinely refused to pay for midwifery services, increasingly defined as an inappropriate, ignorant response to the "dangerous and potentially pathological event" of childbirth.[25] This lengthy campaign took place despite the fact that historically, Black "granny midwives" were a vital part of health care for women throughout the South, particularly the rural South, and were especially crucial in the lives of poor Black women and their babies.[26] The poor women who received aid under these programs in Gainesville were disproportionately Black women, as was (and is) true in many regions of the United States.

The renaissance in American midwifery that arrived in the 1970s, on the other hand, was associated with the overwhelmingly white back-to-the-land movement and in specific, women like Ina May Gaskins of the Summertown, Tennessee, intentional community The Farm, whose 1975 book *Spiritual Midwifery* crystallized a nascent "natural childbirth" movement within the white

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[21] Ibid.; Avery interviewed by Ross, 21-22;

[22] Although the Gainesville Women's Health Center closed its doors in the 1980s, the BirthPlace is still in operation, under the name The Birth and Wellness Center of Gainesville. "Welcome," The Birth and Wellness Center of Gainesville. http://birthwellnessofgainesville.com/home/. Accessed September 26, 2017

[23] The germinal discussion of the African-American midwifery tradition in the Southeastern US remains Gertrude Jacinta Fraser's *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998).

[24] Silliman et al., 72.

[25] Holly F. Mathews, "Killing the Self-Help Tradition: The Case of Lay Midwifery in North Carolina, 1912-1983" in Baer and Jones, 65, 72.

[26] Ibid, 61; Fraser, 210-211.

counterculture.[27] This happened at a moment when midwifery services had already become decidedly unorthodox in American culture. As an upshot of the decades of state suppression of midwifery, most women had come to see the hospital birth as the safer and more valuable mode of childbirth, viewing midwifery, as Jacinta Fraser puts it, as "'second best,' a decision made out of necessity rather than choice."[28] Black women, who were scarcely exempt from the influences of this ongoing campaign to discredit and dismantle midwifery, were no exception. To utilize non-hospital birthing resources in the 1970s was an *au courant* countercultural "alternative," which is to say earmarked by and for those white people with the cultural and economic capital to partake of it. Its theoretically more accessible, less medicalized, and even, in the South, familiarly Black folk roots were not more attractive to Black women. Thus the Black women of Gainesville were both culturally less likely to choose midwifery and economically circumscribed, in ways that white women typically were not, from choosing midwifery (inside or outside of a woman-controlled birth center) as a birth option.

It was in this moment that Avery says she began "to look at myself as a black woman. Before that time I had been looking at myself as a woman."[29] This crucial piece of politicization followed a familiar pattern, one that many other Black feminists had already experienced, discovering, in the words of pioneering Black feminist Frances Beal's influential 1970 essay, the "double jeopardy" of being both black and female. Beal, who founded the Black Women's Liberation Committee of the Student Nonviolent Coordinating Committee in 1968, pointed out that

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[27] Women of all races have, by necessity, been midwives; midwifery expertise and experience is by nature global. There is thus something particularly and tellingly American and white supremacist—as well as thoroughly disingenuous—that in the face of the extraordinary, well-known tradition of Black midwifery in the United States and in Gaskin's open borrowing of techniques from other national and regional midwifery traditions , Gaskin, who is white and did not come from a midwifery-using background, has become widely known both as a "pioneering" midwife and as "the mother of authentic midwifery." See e.g. Maura O'Malley, "Authentic Midwifery: Pioneering Midwife Ina May Gaskin is Known as the Mother of Authentic Midwifery" *Midwives* (February/March 2009), 18-19.

[28] Fraser, 211.

[29] Avery (1990), 77; Silliman et al., 73.

the Women's Liberation movement was overwhelmingly white and middle-class-oriented, and that the mainstream of feminism at the time did not possess, let alone utilize, an analysis of class, race, or imperialism that would help to make feminism relevant to Black women's lives and struggles.[30] Similar realizations had already led to the formation of a number of germinal Black feminist organizations including the five powerful groups whose brief and influential flourishing, as documented in Kimberly Springer's *Living for the Revolution: Black Feminist Organizations, 1968-1980*, were already gone or disintegrating by the time Avery began to experience her own awakening to a critical race politics in 1979 and 1980.[31]

That Avery had not yet been thus politicized may seem paradoxical given the depth of her involvement in health feminism. Yet viewed in another light, Avery's relatively late arrival to Black feminism—movement-wise at least—is nothing if not diagnostic, both of second wave feminism and feminist health's overwhelming whiteness as movements and of Avery's sociogeographic location as a more or less middle-class Black woman in the South. Avery was scarcely unaware of the social changes swirling through the nation. She hardly could have been. Not only did she live through the 1950s and 1960s as a Black woman, but she and some of her extended family members had also had glancing involvement in local and national Civil Rights activism.[32] But by her own admission, Avery did not start out as much of a political creature. Nor would her location in Gainesville, a college town in Florida, well outside the range not only of the hotbeds of the southern

[30] See e.g. Frances Beal, "Double Jeopardy: to be Black and Female" in Barbara A. Crow, ed. *Radical Feminism: A Documentary Reader* (New York: New York University Press, 2000), 160.

[31] Kimberly Springer, *Living for the Revolution: Black Feminist Organizations 1968-1980* (Durham, N.C.: Duke University Press, 2005). See also the instructive commentary on the connections between Black women's anti-poverty and welfare rights organizing and early Black feminist organizing in Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003), 7.

[32] As a college student at Talladega College in Alabama in 1956, Avery was anxiously aware of campus integration happening elsewhere in Alabama; Autherine Lucy, the Black woman who (however briefly) integrated the University of Alabama campus, was for a time sheltered at Talladega College during Avery's tenure. Additionally, Avery's stepfather was among those who attended the 1963 March on Washington, as a representative of the family's church. Avery interviewed by Ross, 7-9.

Freedom Summer but also the radical political momentum of cities like New York, Washington D.C., and Oakland, have afforded her much personal exposure to the radical racial politics developing then in such places.[33] During the most intense years of the Civil Rights movement, Avery was married and raising young children, working with her husband toward professional employment and class security. Due both to geography and her own life trajectory, the Civil Rights movement did not catch Avery up in its currents.

Feminist health, by contrast, did so both by happenstance and by deliberate methodology. The happenstance we have already seen—Avery was assigned to research and present about abortion rights, and this had its consequences. But the feminism in which Avery had become involved was created as a deliberately mobile methodology, its transmission rooted in the broad and relatively impersonal dissemination of information. Books, like Friedan's *The Feminine Mystique*, were as important in Avery's politicization as they were in that of so many other women, and they had the benefit of being buyable and readable with relative anonymity. The Boston Women's Health Book Collective capitalized on books' capacity to spread knowledge and political information without relying on person-to-person or community ties. Their signature offering was *Our Bodies Ourselves*, an immensely popular and internationally distributed text with a central role in creating the women's health movement; the book's ninth edition, which is available in 30 countries as of this writing, was published in 2011.[34] Books' broad accessibility, portability, and usefulness meant that women's health books proliferated as the movement did, with different parts of the movement producing their own health references such as *How To Stay Out of The Gynecologist's Office*, produced in 1981 by

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[33] Those not personally familiar with the geography of the American southeast often underestimate its sheer size and thus its distances: Jackson, Mississippi is 582 miles from Gainesville, Florida. This is nearly forty miles further than the distance from Richmond, Virginia, to Boston (546 miles).

[34] Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives for Medical Control* (New York: Praeger Publishers, 1978),147; Boston Women's Health Book Collective, "OBOS Timeline: 1969-Present", accessed September 3, 2017. http://www.ourbodiesourselves.org/history/obos-timeline-1969-present/; Kline, 14-18.

the National Federation of Feminist Women's Health Centers, and *Witches Heal: Lesbian Herbal Self Sufficiency* (1988) a hugely influential "natural medicine" self-help guide by lesbian feminist Billie Potts. In time, women's health books focused on Black women would follow, but it took Avery's community-building to enable it. *The Black Women's Health Book: Speaking for Ourselves*, edited by Evelyn C. White, and including a selection by Avery, was first published in 1990. The National Black Women's Health Project's own addition to the genre, *Body & Soul: The Black Women's Guide To Physical Health and Emotional Well-Being* (1994), would not follow until several years later.[35]

Health feminists of the 1970s also literally took their show on the road, touring in order to spread the word. In 1971 a self-help cervical exam slide show and a menstrual extraction procedure demonstration, developed by Carol Downer and Lorraine Rothman, toured to 23 cities around the United States, including Gainesville.[36] Downer and Rothman would, upon their return to California in 1972, open the Los Angeles Feminist Women's Health Center. Women's and feminist health films, performances, and other programming also toured regionally and nationally, all created on the basis of the thought that femaleness—and particularly female biology and the experiences it necessitated with medical care—was a sufficiently unifying basis for an extremely broad-based movement. The centrality of information, and the effort made to disseminate that information widely, created a movement that could be entered not only by direct personal connection to others involved in activist circles but through receiving and discussing the teachings of other activists, be they never so geographically distant or personally unknown. This was the political point of entry for

[35] It is by no means coincidental that this was also the time of the rise of the feminist bookstore movement, which existed to create women's community around the books that were coming to define (majority white) women's and feminist culture. See Kristen Hogan, *The Feminist Bookstore Movement: Lesbian Antiracism and Feminist Accountability* (Durham: Duke University Press, 2016).

[36] Sandra Morgan, Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990 (Piscataway, NJ: Rutgers University Press, 2002), 8; Wendy Kline, Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave (Chicago: University of Chicago Press, 2010), 74; Avery interviewed by Ross, 18.

thousands of white second wave feminists, and although it was a somewhat less typical trajectory for women of color, it was Avery's as well.[37]

It makes sense, in other words, that mainstream white feminism and its feminist health offshoots were more familiar and comfortable territory to Avery than were the relatively rarefied and less broadly disseminated woman of color politics that were developing and influencing discourse in large and distant urban centers like Washington, D.C. (National Welfare Rights Organization, 1966-1975), New York City (Third World Women's Alliance, 1968-1979; National Black Feminist Organization (1973-1975)), Boston (Combahee River Collective (1975-1980)), and the San Francisco Bay Area (Black Women organized for Action, (1973-1980)). Avery came to her consciousness of the limitations of the majority-white feminist health movements not because she was immersed in the growing body of activist theory of a developing Black feminism but because she was at home doing the work of women's health in the South, observing firsthand the ways in which, as she would later put it, "white women had no idea about certain issues affecting black women."[38]

This process of observation and connecting the social and political dots of Black women's health continued after Avery left BirthPlace in 1979. As she took on a position heading a Comprehensive Employment and Training Act program at Santa Fe College, a community college in Gainesville, the nature of the work brought her into contact with poor Black women and their lives in a way she had not previously experienced. The interactions she had with students prompted Avery to start questioning the ways in which poverty, racism, lack of educational and health access, and other systemic problems diminished the quality of Black women's lives and possibilities. This

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[37] Avery's presence as the only Black woman in a majority white feminist community isolated her and made her an outlier in more ways than the obvious. Deborah Gray White, for example, argues that "most black women stayed away from majority white feminist organizations" for a variety of reasons centering around white women's preoccupation with their own oppression and inability or refusal to consider the oppressions of black women or the ways in which they as white women might be complicit in those oppressions. Deborah Gray White, *Too Heavy A Load: Black Women in Defense of Themselves, 1894-1994* (New York: W.W. Norton and Co., 1999), 222-223.

[38] Martha Scherzer, "Byllye Avery and the National Black Women's Health Project," *Network News* (May-June 1994), 4.

led to two key developments in Avery's thought and work.[39] First, she developed the notion of the "conspiracy of silence," a culture of protective avoidance, not dissimilar to what Darlene Clark Hine named the "culture of dissemblance" in her work on black women's experience of rape, that Avery maintained kept Black women from talking about their problems and addressing their personal and health issues in the name of sheltering their vulnerability.[40] The task of creating discourse in these silent spaces of Black women's lives swiftly became a major focus for Avery. This new work began with Avery's decision to explore Black women's health as part of her work on the board of the National Women's Health Network (NWHN).[41]

The vast inequities in Black women's healthcare access and outcomes Avery discovered in this research process confirmed her earlier experiences and transformed her life and her life's work. Within a year Avery had formed the nucleus of a Black Women's Health Project as a two-year project within the NWHN, which unusually for a national mostly-white second-wave feminist organization had a political culture that attended to issues of race and class, and began to gather support and funding to support this new mission.[42] [43] But in order for her mission to succeed, Avery knew she had to be somewhere bigger than Gainesville. She chose Atlanta.[44]

Black and Female: What Was the Modality?

It is worth noting that Avery did not choose to relocate to Atlanta because she already had a robust group of Black feminist colleagues and friends in the "Black mecca" with whom to work on her new project. She had spent time in the city, and did know people there. But according to Avery, "none

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[39] Avery (1990), 76-77; Avery interviewed by Ross, 23-25.

[40] Darlene Clark Hine, "Rape and the Inner Lives of Black Women in the Middle West: Preliminary Thoughts on the Culture of Dissemblance," *Signs* 14 no. 4 (Summer 1989), 912-915; Avery (1990), 79.

[41] Avery interviewed by Ross, 25.

[42] Silliman et al., 70-71.

[43] Avery interviewed by Ross, 26-27.

[44] Silliman et al., 73;

of them were black at that time—they were all white."[45] There was strategy in Avery's move, but it was not the strategy of relying on an extant network. Rather, it was the strategy of going to a place where she knew enough people that she could ask for introductions and find her way into the circles she needed to find. Avery might have chosen other cities. Certainly she could have found a similarly large Black community in New York City, as well as in places like Oakland, Washington D.C., or Chicago. As a member of the NWHN Board of Directors, she would have had connections to (white) women's health and feminist community in all these places and many more. Yet for this southern Black woman, Atlanta was the place that made sense when she wanted to begin the particular project of dealing systematically and politically with the health of Black women.

Cities, after all, exist on multiple levels. They are not just localized concatenations of people, nor are they simply buildings and roads, neither are they purely economic entities. Cities also acquire symbolic valence: New York City's brusque big-city arrogance and its open arms as an immigrant-heavy "melting pot," Los Angeles' storied sunny ease and glamour, Paris as "the city of light."[46] Thought of this way, it is not just another big city, or even just another big city that happens to be in the South. Rather, the meanings and the regional significance of Avery's choice should be considered in light of both her racialized position and Atlanta's.

There has been good and valuable work done on the symbolic side of southern identity, for instance Angie Maxwell's important work on what she argues is a culture of "southern inferiority," Karen Cox's *Dreaming of Dixie* and its dissection of the creation of a pop-culture imaginary of a place thought of as "The South," and Tara McPherson's work on nostalgia, race, and gender in the

[45] Avery interviewed by Ross, 26.

[46] Jérôme Monnet, "The symbolism of place: a geography of relationships between space, power and identity," *Cybergeo : European Journal of Geography*, Political, Cultural and Cognitive Geography, document 562, (30 October 2011) accessed 1 October 2017. URL : http://cybergeo.revues.org/24747 ; DOI : 10.4000/cybergeo.24747; see also Geoffrey Parker, *Power in Stone: Cities as Symbols of Empire* (London: Reaktion Books, 2014).

American regional imaginary.[47] But this body of work is overwhelmingly white in its subjects and narrative positionality. Only recently have scholars, many of them scholars of color, begun to assess the meanings and symbolic values of the south and its places in the lives of Black people and Black southerners in particular. Zandria F. Robinson's 2014 *This Ain't Chicago: Race, Class, and Regional Identity in the Post-Soul South*, in fact, argues that Black southerners are central to shaping and generating current southern culture, and that an alchemy that includes place, alongside the more familiar race and class, is central to understanding the "multiple Souths" that have existed both in the past and in the present.[48] A similar viewpoint animates a number of the essays in the 2014 *Critical Studies of Southern Place: A Reader*, in which the reader is called upon to consider generational versions of southern "apartheid" and to "redneckognize" the depth and influence of politics of culture, race, and class.[49]

There is of course excellent recent scholarship arguing that in light of the national pervasiveness of racism, regionalism, and other factors, "southern distinctiveness" is a counterfactual notion, a figment of a historically indefensible popular imagination.[50] But it is possible that the dismissal of "southern distinctiveness" rests on viewpoints from which what is distinctive may not be particularly accessible; the nature of the discipline of history at the present time and historically is typically based in the subjectivities of people who are white, non-southerners,

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[47] Angie Maxwell. *The Indicted South: Public Criticism, Southern Inferiority, and the Politics of Whiteness*, New Directions in Southern Studies (Chapel Hill: The University of North Carolina Press, 2014); Karen L. Cox, *Dreaming of Dixie: How the South was Created in American Popular Culture* (Chapel Hill: University of North Carolina Press, 2011); Tara McPherson, *Rconstructing Dixie: Race, Gender, and Nostalgia in the Imagined South* (Durham: Duke University Press, 2003).
[48] Zandria F. Robinson, *This Ain't Chicago: Race, Class, and Regional Identity in the Post-Soul South* (Chapel Hill: University of North Carolina Press, 2014).
[49] Willam M. Reynolds., ed, *Critical Studies of Southern Place: A Reader* (New York: Peter Lang, 2014). See especially Theodorea Regina Berry, "Reimagining Race: Teaching and Learning in an Urban Southern Elementary School," 213-225 ; David M. Callejo Pérez, "In the Shadows of the New South: Latinos and Modern Southern Apartheid," 173-189; and Faith Agostinonne-Wilson, "Class Warfare: You'd Better Redneckognize," 18-31.
[50] Matthew D. Lassiter and Joseph Crespino, *The Myth of Southern Exceptionalism* (Oxford: Oxford University Press, 2010).

and (sub)urbanites. Distinctiveness, in other words may be found not in either, as Lassiter and Crespino put it, "on a set of empirical differences between region and nation" or "on the presumed divergence of a collective southern identity from national myths and American labels" and yet it may still exist. There is an American south of historically inferiorized and subjugated peoples who have had little opportunity to write their own histories and to whose histories white and especially non-southern historians have for a variety of reasons had sharply limited access.[51] [52]

In light of this, a wholehearted belief in the notion of a "collective southern identity" in a region in which the right to claim and assign public social and civic identities has historically been reserved to whites would seem to require either an unlikely naïveté on the part of historians or else a certain willingness to privilege white narratives, along the lines of Eugene Genovese's well-known willingness to maintain a certain sympathy with enslavers' self-serving paternalist narratives of "my family, white and black."[53] It may in other words be true that there is something demonstrably distinctive about the American southeast that becomes accessible only by thinking and researching

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[51] Ibid., 8.

[52] Among the reasons white and non-southern historians may have limited access to these histories is a disciplinary preference for written sources over oral histories. The historically inferiorized and subjugated peoples of the U.S. south, regardless of race, have also been historically less literate, less monied, and less likely to leave behind and preserve written records. However, even in cases where oral history is used, the social, ethnic, and cultural positionality of interviewers is well known to affect their lines of questioning, modes of address, and the responses they are given. See e.g. Gabrielle Durrant et al., "Effects of Interviewer Attitudes and Behaviors on Refusal in Household Surveys," *Public Opinion* Quarterly 74 (2010), 1-36; Leonie Huddie, Joshua Billig, et al., "The Effect of Interviewer Gender on the Survey Response" *Political Behavior* 19 (1997), 197-220; Darren W. Davis, "The Direction of Race of Interviewer Effects among African Americans: Donning the Black Mask" *American Journal of Political Science* 74 (2010), 309-22; Shirley Hatchett and Howard Schumann, "White Respondents and Race-of-Interviewer Effects" *Public Opinion Quarterly* 39 (1975): 523-28.

[53] Eugene D. Genovese, *Roll, Jordan, Roll: The World the Slaves Made* (New York: Vintage Books, 1976). See especially Part I, section 5, "Our Black Family" (pages 70-75) and forward.

through regionally specific racialized and classed pasts. Not all history is shared. Not all shared history has the same meanings to each group that shares it.[54] [55]

This is the frame in which Avery's move to Atlanta may be seen to carry a distinctive southern and Black resonance. The fact that Avery moved to Atlanta at the beginning of the Reagan-era, neoliberalism-fueled rise of the "sunbelt" is substantially relevant to the history of Black women's health. It was relevant because of Atlanta's historical importance as a hub of Black community and progressive Black intellectual and activist activity since Reconstruction, its cluster of historically Black colleges and universities, its role in the Civil Rights movement, its rising tide of Black city leaders, and its identity as the largest city in the part of the country most known for being affected by the legacies of slavery, Reconstruction, and Jim Crow.[56] Atlanta was not yet a Black feminist hub, but it was a central location for Black community formation, infrastructure, and racial uplift politics.[57] These are the factors that made a move from Gainesville to Atlanta not only a pragmatic choice for a groundbreaking venture in Black women's health, but also a deeply symbolic one.

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[54] An excellent example of the ways in which ignorance of non-shared histories and subcultural knowledges can deeply damage scholarly work can be found in E. Patrick Johnson, " 'Quare' Studies, or (Almost) Everything I Know About Queer Studies I Learned From My Grandmother" *Text and Performance Quarterly* 21/1 (January 2001), 8-9. As Johnson writes, there are "material effects of race in a white supremacist society. " White scholars too infrequently acknowledge their position in that society and its potential or actual effects on their work; it may indeed be invisible to them due to their own positionality. Given the raced and racist histories of the south and southwestern U.S particularly, this seems to me to be a meaningful risk for white historians working in these regions.

[55] Ruth Goldman also argues in favor of this acknowledgment, rather than run the risk of leaving "the burden of dealing with difference on the people who are themselves different, while simultaneously allowing white academics to construct a discourse of silence around race and other queer perspectives." See Ruth Goldman, "Who Is That *Queer* Queer?" in Brett Beemyn and Mickey Eliason, eds., *Queer Studies: A Lesbian, Gay, Bisexual, and Transgender Anthology* (New York: New York University Press, 1996), 173.

[56] See e.g. Numan Bartley, The New South, 1945-1980 (Baton Rouge: Louisiana State University Press, 1995), 136-41, 405-407; Bruce J. Schulman, From Cotton Belt to Sunbelt: Federal Policy, Economic Development, and the Transformation of the South, 1938-1980 (New York: Oxford University Press, 1991), 212-214; and especially Tomiko Brown-Nagin, Courage to Dissent: Atlanta and the Long History of the Civil Rights Movement (New York: Oxford University Press, 2011).

[57] Loretta Ross, in her interview with Joyce Follett, noted that when she moved to Atlanta from Washington, D.C., it was difficult for her to find a black feminist therapist because "…you don't have that overlay of black feminist politics in Atlanta. You have the civil rights thing." (Ross, interviewed by Follett, 154)

This symbolism soon became embodied in Avery's decision, backed by the National Women's Health Network, to plan a national conference on Black women's health. A planning committee made up of Black women Avery encountered through her NWHN connections met for two years to plan what became a watershed event, held on the campus of Spelman College.[58] Spelman had itself just received a grant from the Charles Stuart Mott Foundation that enabled it, in 1981, to establish its Women's Research and Resource Center, a groundbreaking center for research by and about women of African descent. Women's Research and Resource Center director Beverly Guy-Sheftall rapidly became part of Avery's group of Black feminists willing to throw their time, energy, and institutional connections behind Avery's work on Black women's health.

Other Black feminists in the orbit of what is now called the Atlanta University Center—a consortium of Atlanta's five historically Black colleges and universities (Spelman and Morehouse Colleges, Clark Atlanta University, and Morehouse School of Medicine)—who also joined forces. One of them was Lillie Allen, then the Rockefeller Fellow in Population at the Morehouse School of Medicine. Allen would in short order become a co-founder, alongside Avery, of the National Black Women's Health Project, supplying an unusual and powerfully galvanizing narrative consciousness-raising methodology which proved central to the NBWHP's work at the grassroots. This consciousness-raising method became known quickly within the NBWHP simply as "Self-Help." It had nothing to do, however, with the "self-help" traditional to white-dominated feminist health groups. Theirs involved groups that engaged in self-examination of the vulva, vagina, and cervix using speculum and mirror; the NBWHP's, on the other hand, helped women look inside themselves psychologically.

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[58] Sandra Morgen, Into Our Own Hands: The Women's Health Movement in the United States 1969-1990 (Piscataway, NJ: Rutgers University Press, 2002), 45.

Allen's methodology, in the form of a workshop titled "Black and Female: What is the Reality?", made its debut at the First National Conference on Black Women's Health Issues over the weekend of June 24-26, 1983. The conference proceedings, published in the Spring 1984 issue of the Spelman *Messenger*, reveal a rich array of offerings covering issues including patients' rights, the intersection of racial politics and abortion access, Black rural women's issues, the health of imprisoned women, and black women as healers and midwives, in addition to mainstream feminist health standbys like natural approaches to gynecological problems, breast cancer prevention, and information about STIs. But the runaway hit of the conference, which attracted an unexpected and unprecedented estimated 1700 to 2000 women of all ages and class backgrounds from across the country and all over the south, was Allen's workshop. Conference attendees covering the event for radical feminist magazine *off our backs*, wrote "This workshop was so powerful it was repeated twice…. About 400 women attended the second version of this workshop. It was more a sharing experience than lecture or theoretical exercise. When those of us who had not attended arrived on the scene, hundreds of women were in tears, embracing each other or just very quiet."[59]

Reproductive justice activist Loretta Ross, who in 1989 became Director of Programs for the NBWHP, was among the women who attended Allen's "Black and Female" workshop at the 1983 conference.[60] In a 2004-2005 series of interviews conducted by Joyce Follet for the Voices of Feminism Oral History Project of the Sophia Smith Collection, Ross described the experience thus:

> Lillie Allen started talking about her stuff and what she'd gone through and why she was offering this Self-Help process to us, and then she arranged people into groups, broke them down into small groups where we each were to tell our stories…. The next thing you know, you got a room full of black women crying their hearts out, because it's inevitable, as you start peeling back the scabs, it hurts, and becoming very emotional. But at the same time,

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[59] Linda Asantewaa Johnson and Vienna Carroll, "First National Conference: Black Women's Health Issues" *off our backs* 13 no. 8 (August/September 1983), 12-13.

[60] Loretta Ross interviewed by author, 8 November 2016; Ross interviewed by Follett, 203.

> once they dried their tears, it felt like each of us had lost 50 pounds. I mean, it was, like, you have no idea how heavy the baggage is you carry around until you get a chance to discharge some of it. All of a sudden, you felt so much emotionally lighter. Really, a catharsis, a really good, soul-cleansing kind of process.[61]

Allen's "Black and Female: What Is the Reality?" workshops were precisely that. The "Self-Help" process she offered was the facilitation of sharing narratives and conversations about the reality of being both Black and female— the experiences of systemic sexism and racism, poverty and disempowerment, misogyny and misogynoir, life in a white supremacist culture and its effects in virtually every realm of life from education to childrearing to medical care.[62] These conversations provided both context and, at least in broad senses, explanation for the social and cultural factors behind many of the health care disparities that so directly and demonstratively followed racial lines. They also provided cathartic sharing as women named the abuses they had suffered. Because of the cultural "conspiracy of silence" among Black women (as Avery had named it), this was an entirely new experience for the women involved, much as the sharing that took place in many majority-white feminist consciousness-raising groups was an entirely new experience for the women who participated in those. The Black women taking part in these Self-Help groups, however, had very different and culturally distinctive experiences to share:

> "What is the reality?...It's a 15-year-old girl saying it's not fair to be Black, a girl, and Catholic.… It's being 19 with six children, unable to use birth control pills and unable to get

[61] Loretta Ross interviewed by Joyce Follett, Voices of Feminism Oral History Project, Sophia Smith Collection, Smith College (November 3-5, 2004, December 1-3, 2004, February 4, 2005), 205-206.

[62] The term "misogynoir" was coined by Black feminist Moya Bailey in an essay for the Crunk Feminist Collective blog in 2010 to describe "the particular brand of hatred directed at black women," particularly in popular culture and social media. The term, a portmanteau of "misogynist" and "noir" (the French word for "black"), has since become more broadly used to describe this particular hatred of and violence toward Black women in any context. See Moya Bailey, "They Aren't Talking About Me…" Crunk Feminist Collective (March 14, 2010), accessed September 8, 2017. http://www.crunkfeministcollective.com/2010/03/14/they-arent-talking-about-me/; Keir Bristol, "On Moya Bailey, Misogynoir, and Why Both are Important" The Visibility Project (May 27, 2014), accessed September 8, 2017. http://www.thevisibilityproject.com/2014/05/27/on-moya-bailey-misogynoir-and-why-both-are-important/.

sterilized legally. It's June Jordan talking about being the wrong color, wrong hair, wrong gender, wrong age, wrong clothes, wrong sexual preference. It's hearing a white woman say Emmett Till got what he deserved. It's going to a black women's conference on racism and sexism and being asked: if a Black man has a business and a white woman has a business, which one will you support? Of course, no black woman has a business…. It's rage about Black men in relationships with white women and about Black women in relationships with white women. It's women being criticized for being too dark or too light skinned. It's always feeling like an outsider, never belonging anywhere."[63]

A substantial difference in theoretical grounding differentiated Allen's approach to Self-Help from that of standard-issue feminist CR groups. Mainstream consciousness-raising groups often had therapeutic effects but were not predicated or shaped on any psychotherapeutic model.[64] In the 1990s, the NBWHP's materials on creating Self-Help groups emphasized that Self-Help was not meant to be therapy.[65] But this claim fails to acknowledge the origins of Allen's methodology in the "Black and Female" workshops, which was an adaptation, via Lillie Allen's personal experiences of the methodology, of a peer counseling or co-counseling methodology popular among 1970s progressives (particularly on the West Coast) called Re-Evaluation Counseling or RC.

Re-Evaluation Counseling, which came under intense scrutiny in the 1990s for some of the cult-like aspects of its structure and functioning, emerged in Seattle in the 1950s in the work of Harvey Jackins, a labor radical who was untrained in psychology or any related discipline. In 1954,

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[63] "And A Little Child," *Vital Signs: News From The National Black Women's Health Project* vol. IV no. 1 (February 1987), 9. Byllye Avery Papers Box 1, Sophia Smith Collection, Smith College, Northampton, Massachusetts.

[64] See also the Redstockings Manifesto statement "Consciousness-raising is not therapy, which implies the existence of individual solutions and falsely assumes that the male-female relationship is purely personal, but the only method by which we can ensure that our program for liberation is based on the concrete realities of our lives." Redstockings, "Manifesto," in *Notes from the Second Year*, ed. Shulamith Firestone and Anne Koedt (New York: 1970), 113.

[65] The NBWHP's 1998 revised *NBWHP Self-Help Manual* devotes an entire page to the topic "The Self-Help Process Is Not Therapy," defining it instead as "a self-healing community development series of processes and activities." National Black Women's Health Project, *Self-Help Manual* (Revised edition, 1998), 10. Byllye Avery Papers Box 1, unprocessed, Sophia Smith Collection, Smith College, Northampton, Massachusetts.

Jackins was brought before the House Un-American Activities Committee for activities relating to his membership in the Communist Party.[66] Jackins became involved with L. Ron Hubbard's theory of Dianetics, to the extent that he is believed to have participated in establishing L. Ron Hubbard's Dianetics Auditing Center in Seattle in 1952.[67]

Beryl Satter's analysis of Re-Evaluation Counseling points to numerous similarities between Dianetics and RC, including the fundamental belief that human beings were stunted and compromised because of (possibly forgotten) earlier trauma—Dianetics calls these "engrams," RC names them "distress patterns"—that could be eliminated through processes of physicalized emotional release in the form of laughing, crying, "storming," yelling, yawning, and other outbursts. These outbursts would be overseen, and at times enabled, by a trained layperson that Dianetics calls an "auditor" and Jackins calls a "co-counselor." Once this "clearing," as Dianetics and RC both called it, could be made to take place, the individual would "reemerge," as RC put it, as an integrated, fundamentally creative, dynamic, and highly intelligent human being.[68] These ideas, predicated as they are upon the idea of repressed trauma generating neurosis, stem quite evidently from nineteenth-century (and notably Freudian) origins.[69]

The supposed therapeutic mechanism, based as it was in the rejection of emotionally self-repressive societal norms and the rooting-out of "trauma" caused by demands for self-regulation and conformity made of children and adolescents, possessed a certain internal logic and spirit of *épater le bourgeois* that many on the Left, particularly in the 1960s and 1970s, found emotionally

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[66] Dennis Tourish and Pauline Irving, "Group Influence and the Psychology of Cultism within Re-Evaluation Counseling: A Critique" *Counselling Psychology Quarterly* 8, no. 1 (March 1995): 34.
[67] Beryl Satter, "The Left" in Timothy Aubry and Trysh Travis, *Rethinking Therapeutic Culture* (Chicago: University of Chicago Press, 2015), 123-124.
[68] Satter, 123-124.
[69] Michael Kenny, "The Proof Is in the Passion," in *Believed-In Imaginings: The Narrative Construction of Reality*, ed. Joseph De Rivera and Theodore R. Sabin (Washington, DC: American Psychological Association, 1998), 278–9.

satisfying. The forcefulness and immediacy of cathartic outbursts was seen as proof of their efficacy, and as Satter writes, "since emotional outbursts were believed to be curative, provoking them became the goal of many RC activists."[70] Thomas Scheff, a sociologist with lengthy experience within the RC movement, described the methodology in a 1972 *Journal of Humanistic Psychology* article as one where the counselor "refrains from interpretation, advice, comparison, or classification of any kind….His only function is to facilitate discharge. Other modes of counseling are seen as interfering with this process."[71]

RC and feminist consciousness-raising did have some similarities in that both centered around the lay-led sharing of personal experiences. RC's methods and goals, however, contrasted markedly with the typical functioning of feminist consciousness-raising groups. RC used the telling of personal stories, most typically shared as part of a dyad and processed with the goad of a co-counselor, to provoke individual emotional responses seen as cathartic and therapeutic. Analyzing systems of oppression, for instance sexism or racism or homophobia, whether external or internalized, is dismissed in RC in favor of condemning "adultism," the adult practice of criticizing children or telling them what to do and how to behave.[72] The goal, in short, was a sweeping and boundary-free validation of the individual in the name of individual flourishing, explicitly denying either the value or the influence of larger social and cultural systems.

Feminist consciousness-raising, by contrast, relied on a group format rather than pairs, utilizing shared storytelling and personal narrative to illuminate shared experiences of larger social and cultural systems that might otherwise have been invisible. Rather than an individual catharsis,

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[70] Satter, 125.
[71] Thomas J. Scheff, "Revaluation Counseling: Social Implications," *Journal of Humanistic Psychology* 12 (1972), 67-68.
[72] Satter, 125-126. Satter observes that Jackins' work, especially his *The Human Side of Human Beings*, makes claims that RC "healed distress that parents created by telling children how 'to dress, eat, [and] talk.' This implied that parents should allow children to wear sandals in the snow, eat food that would sicken them, and interrupt others, since even reasonable restrictions were forms of 'invalidation'."

the goal of feminist consciousness-raising was the identification of broader patterns and systems of oppression as they operated in the lives of individual women.[73] This, in turn, was meant to enable political and personal action to combat this oppression and repression, both on an individual level and on a group and movement level, and frequently did exactly that. Sharing and validation of individual narrative, in feminist consciousness-raising, was meant to serve the cause of cultural change in the name of the common good.

These two outlooks, seemingly diametrically opposed, contributed to Lillie Allen's "Black and Female: What Is The Reality?" methodology. Allen, at first a stalwart fan of RC methodology, became disenchanted with the overwhelmingly white RC movement's dismissal of racism and other systems of oppression. Allen would later say, in an interview with Loretta Ross, "They wanted to talk about social change, but I couldn't ignore that I was the only black person in the room. They didn't want me to talk about that."[74] Breaking from the RC movement and working from her own experiences of recognizing and confronting both colorism in all-Black communities as well as her own internalized racism, Allen developed a variation on RC's self-disclosure process that incorporated some elements of feminist consciousness-raising to explicitly target the intersection of race and gender.[75] "With 'Black and Female,'" as Silliman et al. write, "Allen had successfully politicized RC and called it 'Self-Help'."[76]

Allen's insistence on the therapeutic value of self-disclosure and cathartic emotion as means of healing internalized racism and feelings of inadequacy dovetailed beautifully with Avery's discovery that Black women lived under the influence of a malign "conspiracy of silence" that prevented them from speaking about, let alone identifying and addressing or politicizing, their

[73] Robin Morgan, "Introduction: The Women's Revolution," in *Sisterhood Is Powerful*, ed. Robin Morgan (New York: Vintage Books, 1970), xxvii.
[74] Allen, quoted in Silliman et al., 75.
[75] Ibid.
[76] Ibid.

problems. Avery had for some time, since her work at the Gainesville Women's Health Center and in her work on the NWHN board, seen the connections between life in a racist culture, a profound cultural insistence on Black women's silent resilience, and the prevalence and intransigence of Black women's health problems writ large.

Allen's model of Self-Help thus became the methodology through which the developing NBWHP set about empowering Black women to "recognize and analyze the components of internalized oppression - whether sexist, racist, or classist—within themselves" in order to re-envision what their health and wellness might look like.[77] By 1984, more than a dozen chapters were formed on the basis of the localized creation of groups of women willing to commit to regular meetings to engage in Self-Help, and by 1989 there were 619 Self-Help groups and 130 chapters across 22 states, with a total of about two thousand dues-paying members.[78] (Actual numbers were likely somewhat larger as these figures relied on groups self-reporting to the Atlanta national office. Not all did.)

Participants eagerly took, and benefited enormously from, the opportunity to tell their stories and fully experience their own emotional reactions in supportive settings in which support and solidarity could develop over time. As Patricia Hill Collins explains in *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, the three most common safe spaces for black women have been in black women's relationships with one another, in African American institutions (such as HBCUs and Black churches), and in black women's organizations.[79] The NBWHP's Self-

[77] "Suggestions for Starting a Black Women's Self-Help Group," Black Women's Health Imperative Papers, Box 1, unprocessed. Sophia Smith Collection, Smith College, Northampton, Massachusetts.

[78] National Black Women's Health Project, "1990-1991 Program Objectives," 1989, 13. Byllye Avery Papers, Box 5, unprocessed. Sophia Smith Collection, Smith College, Northampton, Massachusetts; National Black Women's Health Project, "1989 Accomplishments," 1990. Black Women's Health Imperative Papers, Box 1, unprocessed. Sophia Smith Collection, Smith College, Northampton, Massachusetts.

[79] Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*,

Help groups offered two of those three, and individual experiences of self-help reveal how dramatically affective this work, in these safe spaces, could be.

One woman, writing under the name "Sister Francesca," described her experience of the methodology in the NBWHP newsletter devoted to the "Black and Female" experience. In a NBWHP "Black and Female" workshop held in Burlingame, California, in 1985, "Sister Francesca" told her story of several years of incest at her father's hands to the group, Lille Allen standing behind her, guiding her as co-counseling leader:

> "Lillie Allen takes me back to the first feeling of abandonment I experienced. Dark…quiet…preparing to leave this place continual impulse occurring, trying to suck me through this opening…impulse stops…it's quieter…I am alone…I'm stuck. I come back into the room filled with Black women. The impulse is occurring in *me* now…getting stronger… pushing. Lillie is talking. I do not hear her clearly, my body is slipping, the impulse strengthening. Suddenly I am sliding down, the women on all sides are holding me. I stream through their arms in a quick spurt—I land. My journey ends. I cry with the innocence of the newborn."[80]

Regular participation in Self-Help, both in workshops facilitated by Allen herself and in sessions held in community, was believed not only to create the psychological basis from which Black women could pursue the improvement of their lives but also to be to some extent health-creating, at least in terms of psychological health, by itself. As NBWHP member Valerie Boyd wrote, "When we dare to break the conspiracy of silence, we begin our journey back to connectedness, our journey back to our self. …When we dare to break the conspiracy of silence, we allow ourselves with curious minds, responsive eyes and slightly timid hearts, to revel in self-revelation. When we dare to break the conspiracy of silence, we allow ourselves, with little surprise, to recognize each other as the

second edition (New York: Routledge, 2000), 100.

[80] Sister Francesca, "I Cry with the Innocence of the Newborn…" *Vital Signs: News from the National Black Women's Health Project* vol. IV no. 1 (February 1987), 4.

treasures that we are. And when we fulfill this mission, we will have no need for any healer's art, for then we will already be whole."[81]

"No one can self-help their way to…health care"

Allen's model of Self-Help produced galvanizing subjective experiences that had a remarkable ability to help draw women into community. This was fed by, and simultaneously fed into, Avery's pioneering vision of Black women driving a holistic feminist self-help movement of their own. The moment was clearly ripe, and the Project swiftly attracted thousands. The NBWHP and its Atlanta "Mother House" came to symbolize this new way of imagining and encouraging health and wholeness for many Black women. The existence and centrality of the Mother House was a material part of the Project's success. Women in the community and from around the world visited, met, talked, wept, ate, celebrated, grieved, and worked within its walls. The emotional and psychological impact of the Project created intense bonds between NBWHP members and the organizational core and its headquarters. One woman, Minnie Pryor, narrating a vision of an archetypal African village that symbolized love and connection, referred to the Mother House as a "great Hut in the Village," where the African women she met "shared their pain, beyond pain, with me. I, who 'am too strong to cry," touched my sisters pain which gave voice to my own sorrow. But we did not stay in the dark place. The rise of harmonious, joyous African women in song lifted the pain and seemed to fill every corner of the Village, the universe."[82]

The sheer emotional impact of NBWHP's Self-Help-centered work created intense bonds between participants in NBWHP programs and the organization. It would be impossible to overstate the value, or the genuinely revolutionary nature, of a Black women's organization that was

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[81] Valerie Boyd, "Where is the Love? Black Women Renewing the Ties that Bind," *Vital Signs* (February 1987), 2.
[82] Minnie Pryor, "Quest for the Village," *Vital Signs: News from the National Black Women's Health Project* no. III (October 1991), 10.

sufficiently politically centrist to attract an exceptionally wide population, yet sufficiently politically radical to convince Black women (at least temporarily) to set down their stoicism and resist the demands of respectability politics and uplift agendas in order to name, claim, and mourn their losses and sorrows as well as their resilience and strength. For many women, participation in the NBWHP's Self-Help was clearly a life-changing and liberating experience. Self-Help alone, however, could not eliminate the problems Self-Help revealed. Neither, as it turned out, could it sustain the National Black Women's Health Project.

It is important here to identify the ways in which the NBWHP's model of Self-Help differed from, and went beyond, the version of "self-help" more commonly encountered in the majority-white mainstream of the women's health movement. In the mainstream of the women's health movement, "self-help" typically referred to "self-help clinic," the sessions of teaching and learning self gynecological exam techniques that originated with Carol Downer and the Los Angeles Feminist Women's Health Center. Following Downer and Lorraine Rothman's 1971 self-help exam teaching tour, there were numerous articles, a traveling slide show, and, in 1974, a thirty-minute film eponymously titled *Self-Help Clinic*.[83] This version of self-help was predicated upon a politics of knowledge that postulated that freedom, fairness, and proper medical treatment for women lay in women's acquisition of (especially woman-originated) knowledge about their bodies and their health.[84] This version of self-help was also, like much of the rest of the mainstream feminist health movement, intensively gynecologically and reproductively focused, centered around the question of attaining and maintaining access, preferably woman-controlled access, to contraception, abortion,

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[83] Sandra Morgen, Into Our Own Hands: The Women's Health Movement in the United States 1969-1990 (Piscataway, NJ: Rutgers University Press, 2002), 23.

[84] Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago: University of Chicago Press, 2010), 9-14; Morgen, 16-25; Susan Reverby, "Thinking trough the Body and the Body Politic: Feminism, History, and Health-Care Policy in the United States" in Georgina Feldber, Molly Ladd-Taylor, et al., eds. *Women, Health, and Nation: Canada and the United States since 1945* (Montreal: McGill-Queen's University Press, 2003), 410-411; Susan Reverby, "Feminism & Health" *Health and History* vol. 4 no. 1 (2002), 10-11; Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978), 143-180.

and all other methods of fertility control. This "navel to knees" approach replicated the traditional Western medical establishment's reliance on female sexual and reproductive biology as its guide to what kinds of medicine came under the "women's health" purview. This approach was simultaneously instrumental, since a large plurality of women's interactions with the medical system had to do with sexual and especially reproductive issues, and also essentialist and reductive, limiting the understanding of medical difference primarily to the gross anatomy and physiology of the breasts and pelvis.

For many Black women including those of the NBWHP, this approach was inadequate. They were equally interested as their white sisters in the medical mistreatment of women. However, as Black women, they were highly aware that both as Black people and as women their experiences of mistreatment in sexual and reproductive medical contexts were only one aspect of a centuries-long history of medical malfeasance that continued apace, particularly with regard to involuntary sterilizations. Black women, concomitantly, did not always share their white sisters' conviction that women's acquiring and creating medical information alone was a meaningful solution to misogynist medicine.[85]

Black and white women alike were interested in some of the central offerings of a reproductively-centered women's medicine model, like contraception. As Jessie M. Rodrique among others has shown, a dramatic drop in the U.S. Black fertility rate across the first half of the twentieth century testifies to widespread awareness and assiduous use of fertility control by the 1960s, and numerous influential Black thinkers and organizers from W.E.B. Du Bois to Shirley Chisholm supported Black women's access to and use of contraception.[86] But unlike white women, Black

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[85] Simone M. Caron, "Birth Control and the Black Community in the 1960s: Genocide or Power Politics?" *Journal of Social History* 31 no. 3 (Spring 1998), 545-550; Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003), 4-7; 66-71.

[86] Simone M. Caron, "Birth Control and the Black Community in the 1960s: Genocide or Power Politics?" *Journal of Social History* 31 no. 3 (Spring 1998), 550; Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York:

women had reason to be skeptical that reproductive autonomy was going, for example, to blunt the blows of living in a white supremacist society.

Nor could Black women be certain that white feminism would offer them fertility control on the same terms as white women. From the 1600s onward, the sexuality and fertility of Black people in North America had routinely been defiled and controlled in multiple ways by whites. Several landmark cases in the 1970s revealed that federal funds were still being used to perform involuntary and coercive sterilizations on women of color, particularly in the south, and had been since near the turn of the twentieth century.[87] Byllye Avery, a longtime veteran of the reproductivity-focused mainstream women's health movement, had already learned that for multiple reasons, including the respectability politics that led to Darlene Clark Hines' "culture of dissemblance," there would be no easy or uncritical embrace of a reproductive rights focus as the definition of "health" across the population of Black women.[88]

Nor was reproductive medicine the biggest health issue facing Avery's target population. For Black women, "women's health" had a different meaning, rooted in the multiple intersecting oppressions, risks, and issues of access that diminished Black women's health and lives. The NBWHP's model of Self-Help, consequently, represents a novel method of illuminating the multiple contributors to Black women's health and health problems in a way that shows their overlaps and intersections whilst simultaneously engendering awareness that the compounded effects of racism and sexism specifically on Black women were also at play in their health.

New York University Press, 2003), 77-79; Jessie M. Rodrique, "The Black Community and the Birth Control Movement" in Judith Walzer Leavitt, ed., *Women and Health in America: Historical Readings* (Madison, WI: University of Wisconsin Press, 1999), 293-305. Silliman et al. (2016), 58, points out usefully that birth control has had a role in Black women's "uplift" ideology from the time the Women's Political Association of Harlem advised in 1918 that "a woman could provide a better quality of life and education to her children if she could determine how many children she wished to have and rear."

[87] Johanna Schoen, Choice and Coercion: Birth Control, Sterilization, and Abortion in Public Health and Welfare (Chapel Hill: University of North Carolina Press, 2005), 125-133; Daphne Spain, Constructive Feminism: Women's Spaces and Women's Rights in the American City (Ithaca: Cornell University Press, 2016), 120-122;

[88] Avery interviewed by Ross, 15.

It would be impossible to overstate the value, or the genuinely revolutionary nature, of a Black women's organization that was sufficiently politically centrist to attract a broad enough, yet sufficiently forward-thinking population to engage in the radical act of at least temporarily denying the stoic claims of respectability politics and uplift agendas to name, claim, and mourn their losses and sorrows as well as their resilience and strength. The stories of Self-Helpers made clear that however silenced these factors might otherwise have been, race, class, sex/gender, education, geography, exposure to adverse childhood experiences, life stress, poverty, substance abuse, violence, and many other variables were at play in their lives.[89] In the intervening years, the public health field has come to use the phrase "social determinants of health" to describe this phenomenon.[90] It is entirely material to this discussion to note that in the early Reagan-years moment where white feminists in the mainstream of the women's health movement were narrowing their focus to combat an increasing right-wing backlash against reproductive autonomy, Black feminist health activists were, for reasons of their own, imagining women's health through this radically wide-angled lens.

Avery was not the only health advocate to intuit or act upon the need for a broader approach to the health and well-being of people of color. Jennifer Nelson has illuminated a similarly encompassing stance on the part of clinicians in her work on the Delta Health Center in Mound Bayou, Mississippi, whose prescriptions for glasses of milk and efforts at building community gardens were part of their strategy for addressing rampant endemic health problems.[91] Similarly Alondra Nelson, in her chronicling of Black Panther involvement with medicine, does not limit her

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[89] Reverby (2002), 12-13.
[90] Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (New York: Oxford University Press, 2011), 181-190. See also Joe Feagin and Zinobia Bennefield, "Systemic Racism and U.S. Health Care," *Social Science & Medicine* 103 (2014), 7-14.
[91] Jennifer Nelson, *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015), 15-56; Jennifer Nelson, "Hold Your Head Up and Stick Out Your Chin": Community Health and Women's Health in Mound Bayou, Mississippi" *National Women's Studies Association Journal* 17 no. 1 (Spring 2005), 99-118.

study to Panther clinics but rather reveals the ways that other Panther programs like free meals for children, free groceries for community members, community-run ambulance service, and publicly available sickle cell anemia testing were part of the group's overall health politics.[92] Likewise Jael Silliman, Loretta Ross, Marlene Gerber Fried, and Elena Gutierrez, as well as Sandra Morgen, discuss multiple women of color reproductive health organizations, many with origins in connection to the NBWHP, whose efforts to address health disparities in communities of color also went well beyond the traditionally clinical.[93] The Welfare Rights movement, similarly, took up a broad-based understanding of the needs of impoverished women that included health issues like addiction, occupational safety, contraception, abortion, preventive health care, baby and child health, and other issues as integral to the issue of welfare reform.[94] This notion that creating health in dispossessed, oppressed, and disadvantaged populations required more than just handing out informational pamphlets or performing a few clinical treatments would later become enshrined in mainstream medical thought in the United States via the work of mostly white AIDS crisis activists who popularized the notion of "wrap-around care."[95]

With "Black and Female" and the 1983 conference, the NBWHP had proverbially captured lightning in a bottle. The question was what to do with it. How could the Project best translate the

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[92] Alondra Nelson, Body And Soul: The Black Panther Party and the Fight against Medical Discrimination (Minneapolis: University of Minnesota Press, 2011).
[93] Silliman, et al., 47-48; Morgen, 55-69.
[94] Susan Youngblood Ashmore, *Carry It On: The War on Poverty and the Civil Rights Movement in Alabama, 1964-*1972 (Athens, GA: University of Georgia Press, 2008), 258-259, 261-262; Premilla Nadasen, *Welfare Warriors: The Welfare Rights Movement in the United States* (New York: Routledge, 2005), 91, 168, 200-217; Annelise Orleck, *Storming Caesars Palace: How Black Mothers Fought Their Own War On Poverty* (Boston, Beacon Press, 2005), 76-78, 101-102, 264-264, 284-285; Deborah Gray White, *Too Heavy A Load: Black Women in Defense of Themselves, 1894-1994* (New York: W. W. Norton and Co., 1999), 223-235.
[95] It is by no means a coincidence that many of the early LGBT clinic and AIDS service organization activist/organizers in the 1980s and 1990s had been part of the feminist women's health movement in the 1970s and 1980s. See Lisa Diedrich, "Que(e)rying the Clinic before AIDS: Practicing Self-Help and Transversality in the 1970s" *Journal of Medical Humanities* 34 (2013), 123-128; Lisa Diedrich, "Doing Queer Love: Feminism, AIDS, and History" *Theoria: A Journal of Social and Political Theory*, No. 112, Justice and the Politics of Health (April 2007), pp. 25-50.

abundant products of the Self-Help rhetorical practice into some sort of organizational structure and policy? How could Self-Help's revelations be used to facilitate grassroots health enhancement programs, clinical interventions, and measurably better health outcomes for Black women? The need was clear. What to do about it was another story.

As the NBWHP grew, it became rapidly apparent that the network of Self-Help-oriented chapters was not going to organically develop itself into a centrally organized body with well-developed, well-characterized policy and procedures. It also became apparent that neither Byllye Avery nor Lillie Allen, despite or perhaps because of their visionary capacity, were particularly gifted or inclined to management. The entire organization, in many ways, depended on the presence and continuity of the NBWHP core that sank its roots into Atlanta's fertile cultural soil, with help from an Atlanta city government that had supported the organization and its Mother House with renovation block grants and other resources.[96] National development had largely taken place via a process of oral transmission and in-person community development through conferences and workshops that radiated out from and were often staffed by members of the Atlanta headquarters. Yet Ross recalled that when she joined the Mother House staff she was confronted with a sprawling, enthusiastic, burgeoning national body that "…had no chapter structure in place, no guidelines. People were calling themselves chapters of the Project. They were using our name but they were definitely doing their own thing. Some groups practiced Self-Help, some didn't. There was just no uniformity at all."[97] Part of Ross' role was to supply some sort of infrastructure for the chapters that now spanned 22 states, not only in terms of chapter development and guidelines but in helping to determine what the financial, training, and other support relationships would be between chapters

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[96] Avery interviewed by Ross, 36.
[97] Ross interviewed by Follett, 208.

and the central NBWHP.[98]

A complex and wide-ranging divide had begun to reveal itself within the Atlanta core of the NBWHP. At the heart of the rift was the role of Self-Help. Byllye Avery, along with other core members of the Atlanta headquarters, had begun to think critically about how to translate the personal investment and community-building of the organization into measurable health gains. Several important projects along those lines had been initiated, including the creation of the Center for Black Women's Wellness (CBWW), a community-based wellness center originally sited in 1988 within a housing project in Atlanta's Mechanicsville neighborhood. The center, which became independent of the Project as a standalone non-profit in the mid-1990s, provided a range of services from Self-Help to social services to basic general practice clinical medicine. The CBWW concerned itself with the Project's holistic version of wellness—body, mind, and spirit—and not with the by then typical reproductive health focus of other feminist health clinics.

Two other outward-facing health initiatives not focused on Self-Help methodology were also taken up in the period between 1988 and 1995. 1991, Avery would begin implementing a new program called "Walking for Wellness" that was positioned as a central activity for chapter members, the first systematic body-based intervention the NBWHP would instigate for the entirety of its membership. She would incidentally call, in her regular "From Byllye's Kitchen Table" editorial in the NBWHP's *Vital Signs* newsletter, for Black women to become involved in gynecological self-help in the classic majority-white health feminist speculum self-exam fashion.[99] This call for Black women to become involved in a more mainstream health feminist mode of health education was echoed in the production of the NBWHP's own self-help health reference book, the

98 Silliman et al., 79; Ross interviewed by Follett, 208-209.
99 Byllye Avery, "From Byllye's Kitchen Table," *Vital Signs* (October 1991), 2.

1994 *Body & Soul*: *The Black Woman's Guide to Physical Health and Emotional Well-Being*.[100]

As these initiatives demonstrate, Avery had become critical of strategies that posited self-help or "bootstrapping" as a primary solution to systemic problems like racism and sexism. She was of course aware of all that Self-Help had done in building the organization and generating self-awareness and community among Black women, but she knew it had its limits. So too did some of the Board of Directors. As the NBWHP's Board of Directors Public Policy Committee would write in a 1991 statement opposing the Supreme Court nomination of Clarence Thomas, "no one can self-help their way to employment, housing, education, or health care when basic access is denied based on the discriminatory practices of employers, lenders, and service providers. Promoting self-help solutions as the logic to resolve the issues of lack of access and opportunity in a free society leads to the faulty conclusion that the victims of discrimination are somehow to blame for the outcomes of the practices and policies that have been used against them."[101]

By the time *Body & Soul* had been published, however, four things had happened that indelibly altered the course of the NBWHP, and very nearly put an end to it. First, a rivalry had developed between Avery and Allen, such that loyalties were becoming strained and split. Loretta Ross described it succinctly: "Who's in charge? Is it the woman who's the mother of the Self-Help process, or is it the woman who's the mother of the organization that creates the space for the Self-Help process?"[102] Second, Avery ceased being willing to engage in Self-Help sessions.[103] Third, in 1989, Avery was awarded both the *Essence* Award for Community Service and a MacArthur

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[100] Linda Villarosa, ed., Body and Soul: The Black Woman's Guide to Physical Health and Emotional Well-Being (New York: Harper Collins, 1994).

[101] NBWHP Board of Directors Public Policy Committee, "The Thomas Question" *Vital Signs: News from the National Black Women's Health Project* no. 3 (October 1991), 1.

[102] Ross interviewed by Follett, 209.

[103] Silliman et al., 78; Ross interviewed by Follett, 209-210.

Foundation Fellowship for Social Contribution, one of the MacArthur Foundation's large no-strings-attached monetary awards colloquially known as "genius grants."[104] Finally, the Project was having financial problems, a combination of poor management and budgeting, unpredictable revenue streams thanks in part to inadequately structured financial relationships with chapters, and difficulty providing useful metrics to funders keen on some proof of return on investment.[105] Taken together with the growing desire on the part of some, but not all, of the Project's core members to take focus away from Self-Help and place it on the active creation of health interventions, these things were all powerfully disruptive and their disruptiveness was mutually reinforcing.

Avery's unwillingness to continue participating in Self-Help, a refusal echoed by some staff and board members, signaled different things to different constituencies. For Avery and those loyal to her, Self-Help was a tool, not a *raison d'être*; the Project had attracted a number of "professional, health-oriented women" who "didn't want to talk about their remembered pain. They wanted to talk about how to get more Black women to get PAP smears."[106] To Allen and those loyal to her, it was as Allen said to Loretta Ross: "You have to always be that which you say you are about. As a leader, if you don't check yourself, you are supposed to build a place in which you can be checked. The purpose is to make sure that you are living out that vision and you are consistent with that vision. …That is the value of Self-Help, so that Black women in leadership have a supportive process in which they can be authentic visionaries with integrity."[107]

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[104] MacArthur Foundation, "Byllye Avery: Women's Healthcare Leader, Class of 1989" https://www.macfound.org/fellows/357/. Accessed October 1, 2017; Cox News Service, "Essence Honors Seven Achievers," *Chicago Tribune* (November 12, 1989) http://articles.chicagotribune.com/1989-11-12/features/8901300258_1_editor-in-chief-of-essence-magazine-susan-l-taylor-black-women. Accessed October 1, 2017.
[105] Ross interviewed by author.
[106] Ross interviewed by Follett, 210.
[107] Allen, interviewed by Loretta Ross, in Silliman et al., 78.

Given the ways that the Project's programmatic focus was beginning to shift, with its increasing attention to measurable outcomes and formal processes, along with the growing evidence of the ways in which Avery was lacking in management acumen, the integrity of Avery's vision was certainly under some scrutiny.[108] For Avery's part, she was beginning to consider firing Allen, who, clearly alert to the possibility of a split, made haste to copyright the phrase "Black and female."[109] As tensions mounted, staffers turned against one another. Loretta Ross remembers not only physical altercations in the office but also one memorable day on which one staffer, leery of the potential of losing her job in the tense and unpredictable organizational climate, placed a pistol on her desk as a warning.[110]

In these same months, Avery, who had long insisted on the collaborative nature of the Project and that she was only one among many women responsible for making the Project what it was, was being singled out and celebrated very much as an individual. The highly visible Essence award, followed by the even more visible and extremely lucrative MacArthur Fellowship, served to proclaim Avery to be *the* visionary leader in the organization in ways that could not be ignored.

Avery had been handed a large sum of money and international recognition while the Project struggled to pay its bills and figure out how to manage itself as a grassroots organization. Allen desperately believed in the centrality of her Self-Help methodology, knew exactly how formative and foundational it had been to the Project, and yet felt herself losing power and relevance. The Board of Directors and the staff were wrestling with the problem of having two visionary leaders, neither

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108 Avery interviewed by Ross, 41-42. As Avery put it, "And the thing I didn't know how to do was management – eeewww. Before, we're all together and making all the decisions and all things, got it together, quasi, you know, but then it called for something that needed a structure, and I was just not liking that idea very well. …[T]he basic things you would learn in a book about management I didn't have."
109 Ross interviewed by Follett, 210.
110 Ibid, 211-212.

of whom were competent managers, and an organization that had become too large and too overstaffed to function well without structure… which it also lacked. Something had to give.

Allen left the Project, her consulting contract terminated. In the summer of 1990 Avery acknowledged her lack of managerial skill and stepped aside into an oversight role as the NBWHP hired an executive director, Julia Scott, to oversee day-to-day operations. In an effort to balance the books, Scott and Avery in turn terminated the contracts of many core Project consultants and employees, including Loretta Ross.[111] Avery would later characterize this split and reconfiguration as a "divorce." It was not inapt. In many ways—as Avery recognized—the reconfiguration represented the end of the National Black Women's Health Project as it had come to exist.[112] Flush with MacArthur dollars, Avery was able to take a step back from the Project, "…I could pay all my bills at one time, I could travel. And so, I did a lot of traveling. And I did a lot of being and thinking and resting."[113] Avery's emotional and, at times, physical distance from the Project helped to cement its entry into a new phase of being.

The shift did not please the membership. In the October 1991 issue of *Vital Signs*, Board of Directors chairperson Frances Jemmott-Dory wrote that "some members are not pleased that the mission of the organization and the by-laws are designed so the Project can be more than a self-help organization. To them, I am certain that the governance structure seems more bureaucratic, less personal and accessible…. It probably feels like a loss—a big one…"[114] Then she clarified the relationship of the Board of Directors to the Executive Director, the administrative position created when Avery stepped aside. "The Board of Directors delegates major powers to the Executive

111 Ross interviewed by Follett, 211, 217.
112 Avery interviewed by Ross, 42-43.
113 Ibid., 42.
114 Frances Jemmott-Dory, "The Internal Politics of Black Women's Health: Reflections on the Issues of Governance" *Vital Signs: News from the National Black Women's Health Project* III (October 1991), 12.

Director to carry out the day to day work of the organization."[115] What had begun as Byllye Avery's brainchild and had grown to prominence because of the container Avery's organization had provided for Allen's Self-Help modality, only to be celebrated, in time, as Avery's singlehanded creation was now quite emphatically removed from any one, or more than one, charismatic visionary. The organization would remain based in Atlanta until 1995, but it was never the same.

A New Imperative

For Byllye Avery, Atlanta had proven to be precisely what she had wanted it to be: fertile soil in which the grassroots she wanted to grow would take root and spread with abundant vigor. Indeed, one could go so far as to say that the Project was fertilized and watered there via nourishing connections to the city and to institutions like Spelman College. No garden, however, weeds and prunes itself, or harvests its own fruit for use. Byllye Avery moved to Atlanta in the hopes that Atlanta would provide what she needed to realize her vision of a national organization devoted to Black women's health, and it did. As Loretta Ross put it in 2016, "You really can't overstate the importance of Atlanta. I don't think there's any other place it could have happened. Atlanta has its own history about integration, about Black people's position in the city, in the culture. It made it a friendlier place to base this work."

In the "city too busy to hate," as the 1960s slogan put it, there was an abundant supply of Black women and allies who were eager to join an organization working to better the lives and well-being of Black women. The city's formal infrastructure proved welcoming, but more important was the well-established Black culture of racial uplift, civil rights, and alternative institution-building. Without the resources Atlanta could provide, emphatically including its links to strong Black

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[115] Ibid.

communities across the south that rested on the deep and dedicated presence of women's organizations and women's presence in gender-mixed organizations like Black churches, no amount of vision or desire would have enabled Avery, enculturated and politicized as a feminist in the majority-white mainstream of the health feminist movement, to magically mobilize the community she needed.

This combined alchemically with Lillie Allen's "Black and Female" methodology. Avery's vision was vivid and vital. But just as she initially lacked the Black community and political affiliations to organize Black women effectively on her own, she also came to the work of creating the NBWHP without a tool that would specifically help Black women to discover what lay at the intersection of the two identities around which Avery sought to discuss and politicize health. That this, too, came through the channel of Atlanta as the "Black mecca" cannot be ignored; Allen was one of the women Atlanta brought to Avery's attention, and at the time was on the staff of the Morehouse School of Medicine.

The problems that ensued as the Project developed, of course, were not regional in nature, nor locally specific to Atlanta. Clashes over method and organizational priorities, personality and celebrity, could and assuredly did happen everywhere. Yet it is not only symbolic but instructive that as the NBWHP continued to reorganize and reorient itself, its Atlanta-based history began to vanish, as ultimately the Project itself vanished from Atlanta.

The National Black Women's Health Project is surprisingly and revealingly difficult to research. The available sources are few; the best tool is oral history. Researchers attempting to dive in to this history rapidly discover that the National Black Women's Health Project has no papers of its own, though the National Black Women's Health Imperative—the name it took on following its move to Washington, D.C. in 1995—does, a highly incomplete set of papers housed in the Sophia Smith Collection at Smith College. The papers of major players including Avery and Ross do exist,

and are helpful but not comprehensive, and serve to reinforce the fact that much is missing. Loretta Ross has gone on record saying that this is the fault of the executive directors who came after Allen's departure and Avery's move out of direct leadership, that "it tries to forget its own history… there is a reason why you can't find records, there is a reason why what records are found, people are clinging to. It's all caught up in dysfunctionality."[116] Further to this point Ross has said

> "The Project is not the Imperative. One of the things I noticed is how much they try to bury their own history and distance themselves…. The Project didn't keep its records, that was part of the reinvention. That was on purpose. I criticized the people, Cheryl Boykins, the second director of the Center for Black Women's Wellness, was one of them, who chose that intervention. Documentation has either been suppressed or just destroyed. I don't know how or why it happened. I am witness to the consequences, I had to spend years persuading people who had records to donate them to Smith…. If you talk to Julia Scott, the woman who moved the Project to D.C., ask 'Why didn't you maintain the integrity of the record?' "[117]

The shift from Atlanta to D.C., from grassroots organizing and creating webs of deep emotional experience and commitment that spread nationally from a southern base to a professional organizing, research, and lobbying organization that maintains only a few token chapters, was all of a piece. Cities and places, as we have noted, have meanings. In the trajectory of the National Black Women's Health Project, Atlanta did not just symbolize but helped to embody the power of sisterhood, of emotion, of deep pain, of sharing, of being Black and female, and of hope and yearning to create better health for Black women. Washington, D.C., is the hub of power, the place where laws are made and federal funds are allocated. It is a city where the problems and concerns of a nation converted into hours of polysyllabic speeches and convoluted, nearly unreadable prose by a bureaucracy led almost uniformly by formally-dressed imposing white men who often ply their trade

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[116] Ross interviewed by Follett, 220.
[117] Ross, interviewed by author.

inside formally-designed imposing white buildings. By definition it is not southern but national, not regional but federal. "Inside the Beltway" is synecdoche for a reason, and when we note that the National Black Women's Health Project moved to D.C., it tells us a great deal of what we need to know: that as it lost its visionary leadership and its Self-Help lifeblood, as it destroyed its own Atlanta history and left the south, the National Black Women's Health Project went from being integrally by and for black women to being, in a pointed way, only *about* them.

Chapter Five

Business as Usual:

The Atlanta Feminist Women's Health Center and the Art of Feminist Health Survival

On the surface, there does not seem to be much of a story to tell about the formative years of the Atlanta Feminist Women's Health Center. By comparison to many sister organizations of the era, including several that form part of this project like the Tallahassee Feminist Women's Health Center or the Mari Spehar Health Education Project, the AFWHC's founding period was fairly smooth and undramatic. This was partly because, when it came to establishing feminist health organizations, it paid to be a younger sister: as Sandra Morgen and Jennifer Nelson both observe, the fact that the AFWHC opened its doors in 1977 meant that it had the support and the experiences of numerous sister clinics to draw upon.[1] In particular, as the clinic's name implies, the AFWHC came out of the stream of clinic foundation based in the pioneering self-help based Los Angeles Feminist Women's Health Center and its founders Carol Downer and Lorraine Rothman.[2] In years to come, the group of feminist health organizations that grew from this background would become the Federation of Feminist Health Centers, and among the characteristics they shared was a tendency for clinics to form thanks to enthusiastic reactions to self-help vaginal and speculum exam groups, which Downer and Rothman famously initiated.[3]

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[1] Sandra Morgen, Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990 (New Brunswick, NJ: Rutgers University Press, 2005), 100; Jennifer Nelson, More Than Medicine: A History of the Feminist Women's Health Movement (New York: New York University Press, 2015),124-125.
[2] Morgen, Into Our Own Hands, 100; Nelson, More Than Medicine, 125.
[3] "Excitement always led to action in the FFWHC…" Morgen, *Into Our Own Hands,* 100.

This was certainly the case for the AFWHC, which in many other ways also followed what had become a fairly predictable pattern for clinical feminist health organizations to establish themselves: one based in organized, intentional, and systematic inter-organizational transfer of knowledge. Archival evidence, as well as the historiographical literature beginning with Sheryl Burt Ruzek's 1978 *The Women's Health Movement: Feminist Alternatives to Medical Control*, consistently show communications between and among women's health organizations to have been lively and frequent. Knowledge transfer among women and groups of women was central to the movement's functioning, particularly with regard to establishing new organizations and clinics.[4] As the archive shows, health feminists did so via several methods, which included extensive formal training visits to established clinics. Some of the members of the Mari Spehar Health Education Project spent time visiting and learning from Iowa City's Emma Goldman Clinic, for example, and the Atlanta FWHC's ties to the Tallahassee FWHC included, but were certainly not limited to, many visits that amounted to practicums.[5] [6]

The nature of these trainings, as well as the ongoing informational exchange that took place in newsletters, phone calls, letters, and the occasional conference, was not limited to medical procedures and clinic administration. They were also overtly a political education, in which feminist expectations of nonhierarchical organization, collective consensus decision-making, job rotation, and ideas about economic accessibility, the value of labor, and the appropriate relation of feminists to profit were part of the curriculum. As a mode of intensive politicized socialization as well as a crash

[4] See Morgen's Chapter 4, "Into Our Own Hands: Feminist Health Clinics as Feminist Practice" in Morgen, *Into Our Own Hands*, 70-105. Also see the abundant references to knowledge-sharing and feminist community as the locus of medical and health learning in Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978,) 27-33, 53-64, 143-180.
[5] Zeryn Zaire, "The Mari Spehar Health Education Project, Fayetteville, Arkansas" in Dorothy Battenfeld and Elayne Clift, eds., *Patterns for Change: Rural Women Organizing for Health* (Washington, D.C.: National Women's Health Network, 1981), n.p. A photocopy of this publication can be found in Fayetteville Women's Library Collection, Box 28, Folder 26-1, "Women's Health Movement" University of Arkansas Special Collections.
[6] Lynne Randall interviewed by "R", n.d. [circa 2011] Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center. See also Nelson, *More Than Medicine,* 124.

course in movement history delivered by those who lived it, it was made up not only of stories of individual clinics' struggles and triumphs but also of frequent infighting between feminist groups and individuals. The effort to create women-controlled, women-run medical environments required its own processes institution-building, with all the elements of social, organizational, procedural, economic, and emotional work that implies. Particularly during what Jennifer Nelson refers to as the "period of powerful social and political upheaval and reform" from the late 1960s until the middle 1970s, this meant nothing short of a heady and galvanizing reimagining of what women's medical care might be and what it might allow for.[7] In all of these ways, the AWFHC's 1977 birth took place exactly as the historiography of the movement might predict, an emergent community-based feminist organization coming to life in the midst of a web of community-based feminist organizations and in dialogic relationship with each of them.

Unlike its elder sister organizations, however, the AFWHC was born into a different political climate, one that in some ways constituted a reaction to the very types of change that the earlier feminist health movement attempted to create. A number of feminist health related legal actions, including *Feminist v. Mohammad* and several lesser cases involving allegations of everything from trespassing to practicing medicine without a license, had taken place, compromising health feminists' ability to do their work and generating adverse publicity. More importantly, however, opponents of legal abortion had begun to organize themselves locally, nationally, and more importantly, legislatively: the 1976 Hyde Amendment had abolished federal Medicaid funding for abortion care, sending a decisive and unmistakable message about the federal government's willingness to programmatically or systemically support the reproductive autonomy whose constitutional legality the Supreme Court of the United States had upheld only three years earlier.[8]

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[7] Nelson, More Than Medicine, 124.

[8] There were other factors as well, particularly in the form of an anti-feminist, anti-lesbian and gay backlash personified in particular by activist Phyllis Schlafly; see Nelson, *More Than Medicine,* 124, 133-157. A burgeoning religious right,

In what might be considered a case of precocious puberty for a grassroots health organization, the AFWHC was no sooner up and running than it was dealing with the kind of large-scale opposition that older feminist health organizations had not had to negotiate at their outset. The AFWHC did not get to enjoy the short but tangible window of positive possibility that early feminist health organizations experienced in the wake of *Roe v. Wade*. There simply was never a moment in the AFWHC's existence where it did not have to consider and navigate the fact that there was a concerted effort afoot to thwart its goals and curtail its operations.

Taken together, these factors help to explain what otherwise appears, by comparison to other feminist health organizations, to be an unusually conservative approach to health feminist organizational practices. The AFWHC's inheritance from other organizations, particularly other FWHCs, has been noted by Jennifer Nelson: "… the Atlanta FWHC had advantages as an institutionalized product of earlier feminist struggles."[9] But so has its early retreat from earlier ideological goals, such as antihierarchical leadership.[10] Similarly *derrière-garde* organizational tendencies in other feminist clinics had, earlier on, proven wildly controversial at the Los Angeles FWHC, where reactions burned up the pages of national feminist publications with searing accusations and ferocious defenses. By contrast, within a few years of its opening the AFWHC had not only shifted away from a nonhierarchical, consensus-driven management and decision-making model, it had also abandoned other practices commonly seen by health feminists as being not just aspirational but central to their feminism. Job rotation, pay equality, and even mandatory participation in self-help exams rapidly fell by the wayside at the AFWHC. None of this provoked

particularly as attached to a rising new mode of Republicanism, also played a strong role in this social conservatism. Darren Dochuk's discussion of the quasi-millenialist evangelical Protestant obsession with "decaying" American mores in 1976, the year of the U.S. Bicentennial and the first post-Watergate Presidential election in *From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism* (New York: W.W. Norton & Co., 2011), 354-361.

[9] Nelson, More Than Medicine, 125.

[10] Ibid., 125.

so much as a peep from Atlanta countercultural weekly newspaper *The Great Speckled Bird,* nor elicited mention in the otherwise strongly opinionated pages of the Atlanta Lesbian Feminist Alliance newsletter. It does not seem to have been much registered within feminist health circles, either. As for national feminist periodicals, including the one that had enthusiastically served as the locus of a pamphlet war about the Los Angeles FWHC, there was complete silence.

In their own recollections of this period of change, the AFWHC's founding mothers claimed these ideological shifts happened on a wholly pragmatic basis: as clinic co-founder Lynne Randall would put it in a later interview, "you can't be in meetings all the time, people have to get served."[11] At the same time, the archive as well as oral histories suggest several other factors in play. Acknowledging the presence of external pressures on feminist health organizations, and particularly abortion providers, provokes a reconsideration of the extent to which some feminist ideological priorities were, or could be, highly relevant to individual organizations. If we were to posit a spectrum of health feminism that varied along axes other than the traditional "liberal" vs. "radical" feminist model, such a spectrum raises questions about the ways in historians understand the functioning of late "second wave" feminism. By drawing on the work of Stephanie Gilmore, Jo Reger, and Clare Hemmings, it becomes possible to consider such reactive strategy not through a purity politics lens, as some sort of failure of a morally imperative radicalism, but as successful survival tactics for an increasingly parlous climate.[12] Well before the infamous descent of Operation Rescue protesters on Atlanta's abortion clinics during the 1988 Democratic National Convention, not only day-to-day operational pragmatism but an organizational and identity-political long game

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[11] Lynne Randall interviewed by "R", n.d. [circa 2011] Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center. It should be noted that while many of the archival sources cited in this chapter were in the private collections of the Atlanta Feminist Women's Health Center at the time that they were consulted, they have since been added to the Atlanta Feminist Women's Health Center papers at the Sallie Bingham Center for Women's History and Culture at Duke University.

[12] Clare Hemmings, "Telling Feminist Stories," Feminist Theory 6 (2005) 115-139; Stephanie Gilmore, Groundswell: Grassroots Feminist Activism in Postwar America (New York: Routledge, 2013); Jo Reger, Everywhere and Nowhere: Contemporary Feminism in the United States (New York: Oxford University Press, 2012).

had become crucial. In the biggest city in the south, then, we witness a brand new feminist women's health organization of the 1970s opening its doors only to confront a new and dangerous set of demands, forcing an accelerated development that was also, in some ways, a retreat.

Birth of the Clinic

The early origin story of the AFWHC is very nearly a *locus classicus* of the 1970s feminist clinic formation process. This is valuable not only as a historical model, but also because it helps us to understand the meaning of later divergence from some of the ideological principles that underlay its birth.

The "gateway drug" of feminist women's health activism, for both of the "founding mothers" of the AFWHC, was the self-help speculum exam. Lynn Thogersen and Lynne Randall came to the self-help movement at slightly different times, but in both cases, it was the experience that activated their health feminism and ultimately prompted them to make the move toward community-building and organizing. This was precisely what southern Californian feminist women's health center founders Carol Downer and Lorraine Rothman, the women who developed and evangelized the self-help exam practice, hoped it would do: within a year of Downer's first forays into small-group self-help gynecological exams in 1971, over 2000 women had attended a meeting or demonstration. By 1975, Downer and Rothman had toured the United States spreading the word and the speculum blades, and self-help gynecology demonstrations had taken place not only in the US but in Canada, Mexico, and at least seven European countries.[13]

As Sandra Morgen writes, "Self-help was the cornerstone of the feminist clinic."[14] Its message and value were simultaneously philosophical and experiential. Participating in self-help

[13] Ruzek, The Women's Health Movement, 54.
[14] Morgen, Into Our Own Hands, 72.

gynecology allowed women to do and to view things—use speculums, view vulvas and cervices—that had previously been jealously guarded as part of the (typically male) physician's purview. Self-help gynecology liberated that knowledge for laywomen's self-directed, self-selected, nonprofessional use, tapping into feminist philosophies regarding bodily autonomy, educational access, and the epistemic primacy of experience.[15] For college-educated white health feminists in particular, arrogating unto themselves the ability to engage in this "doctors-only" practice was a satisfying redress of knowledge unjustly and selfishly restricted as part of what Sheryl Burt Ruzek called the physician's "territorial prerogatives."[16] To seize the handles of the speculum was, symbolically at least, to seize the means of production of both medical knowledge and medical care of women's bodies. For health feminists, it was widely touted as a transformative spiritual, personal, and political experience that galvanized feminist health activism.

It was exactly so for both Lynn Thogersen and Lynne Randall, the women who were the founding mothers of the AFWHC and who stayed with the clinic for 17 years after its founding. Thogersen was the first to encounter it. Living in Tallahassee, Florida, as a young woman, she encountered self-help gynecology in the feminist community that surrounded Florida State University, including the founders of the Tallahassee Feminist Women's Health Center. [17] She was riveted by the promise of women's self-help health care and became part of the crew of volunteers who painted walls and worked in the equipment room to enable the health center to open its doors.[18] Little did Thogersen know, as she shared self-help sessions, painted skirting-boards, and

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[15] Morgen, 7 *Into Our Own Hands,* 2; Ruzek, *The Women's Health Movement*, 53,113-116, 172-174, 187-188. See also Michelle Murphy, "Immodest Witnessing: The Epistemology of Vaginal Self-Examination in the U.S. Feminist Self Help Movement," *Feminist Studies* 30, issue 1 (April 2004), 115-147.

[16] Ruzek, *The Women's Health Movement*, 67-72, 127-128.

[17] Lynn Thogersen interviewed by "R", n.d. [circa 2011] Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center.

[18] Ibid.; Janet Callum interviewed by "R", n.d. [circa 2011] Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center.

sterilized specula in Florida, but she was already beginning to participate in what had become a semi-formalized "learning by doing" process of learning how to create a feminist women's health clinic.

Lynne Randall, by contrast, first encountered self-help gynecology somewhat later, in the context of a 1975 midwifery conference in Atlanta. Thogersen, newly transplanted to Atlanta, also attended the conference, in part to see friends from the Tallahassee FWHC who had come north to give workshops on feminist self-help gynecology at the conference. This, Randall would later point out, had not been coincidental. The Tallahassee health feminists deliberately went to Atlanta to teach as a form of recruitment, hoping to find Atlanta health feminists who might be interested in forming a women's clinic that would put feminist health care in close proximity to high-powered health care organizations like the Centers for Disease Control, Emory University, and Grady Hospital.[19]

And so they did. In the aftermath of the conference, Thogersen and Randall became fast friends, working together to create a local self-help gynecology group that met in Randall's apartment living room and operated thanks to supplies obtained through the Tallahassee FWHC.[20] It did not take long, however, before Thogersen and Randall became frustrated that there was no feminist clinic in Atlanta to which they could refer self-help participants who had questions they couldn't answer or who needed care beyond the possibilities of self-help.[21] It was time, they decided, to try to found one. The two women decided to share an apartment to cut their expenses and increase their ability to organize. Along with other interested feminist friends, they regularly visited the Tallahassee clinic on the weekends to volunteer and learn: "A group of us would drive down on Friday night and work in their abortion clinic on Saturday so we could actually see more

[19] Lynne Randall interviewed by "R", n.d. [circa 2011] Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center.
[20] Thogersen interview (circa 2011).
[21] Thogersen interview (circa 2011).

what that meant to have a feminist clinic or feminist approach to abortion care and then we would head back to Atlanta."[22] They also talked at length with Carol Downer and Lorraine Rothman. In an unusual act of friendship and feminist commitment, Randall quit her job and Thogersen supported them both, allowing Randall to work full time on getting the clinic up and running. They did so on a skinny shoestring indeed, with small loans from their mothers and about a hundred dollars a week in start-up assistance from the Los Angeles FWHC.[23] Finally, the summer before opening the AFWHC, both Randall and Thogersen spent time in the Tallahassee and Los Angeles Feminist Women's Health Centers, respectively, garnering yet more hands-on experience in the ideologies and actualities of running a clinic.

Back in Atlanta, with little money to spend, the two twentysomething single women found it difficult to find a landlord willing to rent them space to open an abortion clinic. Eventually they found a space in Atlanta's Midtown neighborhood, on 18th Street, with a landlord Thogersen characterized as "desperate to rent the space," and set to work.[24] The Atlanta Feminist Women's Health Center filed articles of incorporation in the state of Georgia on 13 October 1976 and opened their doors to the public in February, 1977. They offered a basic lineup of clinical reproductive health services including contraceptives counseling, pregnancy testing, self-help exam sessions, abortion counseling, and abortion in what photos show to have been a cozy, homelike environment that featured houseplants, feminist art, heating pads, and thrift-store rocking chairs in its recovery room and second-hand equipment in its clinical spaces.[25]

As the clinic opened, it did so incorporating organizational practices similar to those originally taken by its older sister teacher organizations in California and Florida. Drawing from a

[22] Randall interview (circa 2011).
[23] Thogersen interview (circa 2011).
[24] Thogersen interview (circa 2011).
[25] Descriptions of the physical spaces of the AFWHC are based on photographs in the AFWHC's private collection.

version of feminism that viewed hierarchies as patriarchal and "male," the AFWHC established itself as a collective that valued collective and consensus decision-making as part of its approach to feminism.[26] The AFWHC also began operations with other unconventional processes in place, including aggressive deprofessionalization and knowledge-sharing accomplished via job rotation.[27] Early core staff member Janet Callum recalled that "…everyone who worked there basically did everything. Jobs were not different, you did everything: working in the abortion clinic, doing the books, to cleaning the bathroom. You really, literally did it."[28] This was a means of liberating knowledge for women's use, but also another mode of resisting hierarchies. Antihierarchical deprofessionalization efforts extended to patients, too. At the AFWHC as in some other clinics, women were encouraged to perform some aspects of their own health care. Many learned to read their own clinical charts, and some even learned to take their own blood pressure and to participate in performing and interpreting their own pregnancy tests.[29]

Ensuring a feminist commitment to the organization and to its antihierarchical ideologies of deprofessionalization and information liberation also fueled the AFWHC's initial insistence on allegiance to particular tenets of health feminist politics. This is revealed, for example, in some of their early hiring and personnel paperwork, which stipulated that staffers be willing to participate in the same kind of self-help vaginal exam groups that had first drawn Thogersen and Randall into the movement. Mandatory participation in a community of women seeking direct and unmediated

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[26] See Morgen, *Into Our Own Hands*, 72. Winifred Breines' discussion of the importance of participatory democracy practices within the mid-1960s Student Nonviolent Coordinating Committee explains the core historical context of this ideology of antihierarchical organization as a way to combat racist and sexist power differentiation. Winifred Breines, *The Trouble Between Us: An Uneasy History of White and Black Women in the Feminist Movement* (New York: Oxford University Press, 2006), 22-27.

[27] "Rotation of Clinic Jobs," n.d. Box 7, folder "Quality Assurance Mechanisms." Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

[28] Janet Callum interview, circa 2011.

[29] Maureen Downey, "Women's Health Center: Founders 'Were Very Brave'" *Atlanta Herald-Tribune* [n.d.] Private Collection of the AFWHC.

bodily self-knowledge was, as Callum put it, "a way to demystify health care…" and to ensure that women working at the AFWHC saw themselves as no different from the women they served.[30]

This emphasis on a nonhierarchical environment created by and for women, focused on women's participation and knowledge sharing, does not appear to have created any dramatic obstacles to clinic functioning in the early days of clinic operations. It did not, at least, seem to impede clinic activity during what was a very busy time: the AFWHC saw 609 women in-clinic during its first year, 198 of those patients receiving abortion care. In addition, the fledgling clinic was very present in the community, maintaining a presence at the Atlanta chapter of NOW, attending the Poor People's Fair, the Gay Rights March, and the Peachtree Walk as well as participating in the Georgia Abortion Rights Action League (GARAL) and the National Abortion Foundation (NAF).[31]

Meeting minutes from early Board of Directors meetings give evidence of the kinds of problems that might plague any grassroots, not-for-profit social services organization. The AFWHC staff needed a photocopier and more office space, wanted to figure out how to network more effectively with other local organizations, and were concerned about doing effective outreach within the region.[32] The first few years of meeting notes do not explicate, nor even suggest, internal problems that would lead to any administrative or organizational changes.

Yet it is simultaneously clear that there were some internal tensions at the AFWHC, where its distinctively feminist-identified organizational priorities and methods were concerned. We know this not because of a trail of complaints or arguments in the archive, but because the methods quietly changed. Over the course of four or five years, the AFWHC dropped job rotation and other

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[30] Callum interview, circa 2011

[31] "Annual Meeting, 1978," March 29, 1978. Box 17, folder "Annual Meeting, 1978." Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

[32] Atlanta Feminist Women's Health Center Board Meeting notes, 3/28/78 (typed 3/30/78) and 4/26/79. Private collection of the Atlanta Feminist Women's Health Center.

deprofessionalization practices from its routine and stopped requiring employee participation in vaginal self-exam group. Most importantly of all, the Center stopped relying on consensus decision-making and a collectivist, anti-hierarchical organizational structure, shifting to a more traditional executive hierarchy model with clear ramifications concerning power, economics, and public image.

"Inimical to the concept of self-help and feminism"

By the time these changes took place at the Atlanta FWHC, Center administrators and staffers would have known full well that such alterations to expected feminist health methodologies and ideologies had the potential to explode into a firestorm. Several years prior, in 1974, some similar changes in the pioneering Feminist Women's Health Centers of southern California had resulted in months of heated controversy, which (conveniently for historians) was carried out in large part in the pages of Washington, D.C. based radical feminist national newsmonthly *off our backs*.

This pamphlet war began in June of 1974 and flourished until October of that year before dwindling down to occasional salvos in the form of letters to the editors. It began with a ferocious, collectively-written attack in which twelve former employees of the Los Angeles and Orange County Feminist Women's Health Centers charged these clinics (among the first feminist health clinics to exist) with oppressing women in a variety of ways.[33] The California FWHCs were accused of being "fascist" in addition to racist, sexist, and ageist.[34] Former workers railed against a lack of structured channels for airing grievances, lambasted clinic founders and core staffers with longer tenures for monopolizing the "'glorious jobs,' like calling the doctor or meeting the public," and accused clinic founders of economically exploiting the workers in an environment of political paranoia and

[33] Judy Leste, Shannon Bennet, Cathie Pascoe, Linda Aldous, Joanne Cline, Lorna Rocha, Sue Keeler, Lorey Bonante, Dianne Sultana, Terri Greenberg, and Zoe Tafoya, "What is 'Feminist' Health?" *off our backs* vol 4 no. 7 (June 1974) p. 2-5.

[34] Ibid., 3.

emotional manipulation.[35] Throughout it all, they spoke of disconnects between feminist principles of collectivity, consensus, community, equality, "sisterhood," and shared goals and what they perceived as the unfeminist twisting of these principles in practice at the FHWC's. Of particular importance to the former employees were feelings that non-core staffers were excluded from decision-making, a lack of equal participation, a disproportionate amount of required "shitwork" such as typing and telephoning, a lack of "sisterhood," and the use of feminist commitment as an emotional and political cudgel to compel dissenters to comply.

Throughout this controversy, both sides waved the flag of radical feminist ideological purity. A prefatory editorial in that June 1974 issue of *off our backs,* entitled "Positions of Greatness," sided unequivocally with the former workers. The *off our backs* editors characterized Carol Downer as the head of "the Downer Dynasty" of dominant, controlling West Coast health feminists not only capable of partaking of the benefits of a "star system" but of unabashedly creating themselves as the "stars."[36] Such seeking or even accepting notoriety, fame, or greatness was viewed as intrinsically masculine, hierarchical, and anti-feminist; *off our backs'* editors claimed that "institutionalizing the value and importance of one person over another" was the "traditional tactics of husbands and kings, fathers and presidents," concluding "that the structure of the F.W.H.C. is inimical to the concept of self-help and feminism."[37]

The *off our backs* editors did not publish such views as entirely one-sided. They sought out and published a short vision statement by Carol Downer that had been previously published in a feminist health newsletter called *The Monthly Extract.*[38] In this piece, Downer attempted to explain

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[35] Ibid., 3-5.
[36] Ibid., 4.
[37] Editors, "Editorial: Positions of Greatness" *off our backs* vol. 4 no. 7 (June 1974). 1.
[38] *The Monthly Extract: An Irregular Periodical* was published in Connecticut by mother and daughter radical feminist duo Lolly and Jeanne Hirsch. Particularly concerned with health feminism, it billed itself on the masthead as "Communications Network: Global Gynecological Self-Help Clinics."

her own approach to feminist ideology and clinic organization, asserting that any woman working in the name of the betterment of their own sex could "rest assured that she will never be exploited" and accused those who insisted on perceiving exploitation within the FWHC of lacking adequate feminist consciousness. Downer also tried to equivocate through an appeal to feminist ideology when it came to hierarchy. She openly admitted that there was a hierarchy at FWHC, but denied that it was unfeminist: "There is a hierarchy at the FWHC; it is *not* a hierarchy that is based on membership in a dominant group (white race, male sex or American). Rather, it is primarily based on amount of commitment and length of time worked…"[39] In refuting charges of hierarchal power imbalances, Downer insisted on the liberating potentials of meritocracy: "The policy of the FWHC is to encourage all staffers to become directors," continuing with "if all staffers elected to fulfill the objective criteria and became directors, this would eliminate differences in in rank (result: no hierarchy)."[40]

While Downer's statement suggests that at least some of the former FWHC workers' complaints were rooted in truth, it is also clear that *off our backs'* editors made the decision to air, and side with, the former workers' complaints without investigation or seeking out a response. It was a forceful gauntlet-throwing, even considering that in radical feminist circles where theoretical apparatus was often seen as definitive, to say nothing of form-conferring, such intense critique and ideological clashes were not uncommon. Such ossification of theory within the feminist movement of the 1960s and 1970s, as historian Barbara Ryan instructively points out, often led to a "demobilization" of actual feminist activism as "disputes over ideological purity overr[o]de common political concerns."[41]

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[39] Carol Downer, "What Makes the Feminist Women's Health Center 'Feminist'?" *off our backs* vol. 4 no. 7 (June 1974), 2.
[40] Ibid.
[41] Barbara Ryan, "Ideological Purity and Feminism: The U.S. Women's Movement from 1966 to 1975," Gender and Society 3 no. 2 (1989), 251.

The subsequent issue of *off our backs*, accordingly, featured a 72-point rebuttal by the southern California FWHC complete with three appendices.[42] It also contained a number of angry letters from FWHC supporters, including some who cancelled their subscriptions to *off our backs* in outrage.[43] The next several issues sported a range of responses from other feminist health organizations as well as individuals, demonstrating the geographic range and influence of the controversy. The Detroit Women's Health Center sided with the disgruntled former FWHC employees, while the Washington, D.C. Rape Crisis Center took issue with what they perceived as *off our backs*' lack of appreciation for feminist leadership and asked that "those *not willing* to make this commitment, please respect and support those who do, for the sake of us all."[44] A Houston woman, on the other hand, wrote in with a personal story of Carol Downer and other FWHC staffers' generosity with their time and expertise.[45] But another feminist periodical, Los Angeles' *Sister* newspaper, while commending *off our backs* for its "very provocative article," pointed to the charges leveled against the FWHC as being perhaps more meaningful as a general critique than a specific set of allegations, hoping that "your article will generate debate and will lead to favorable resolution of a problem that is so important to our movement."[46]

The very public, very politicized battle between the southern California FWHCs and their former employees made it clear that there could be significant consequences, at least in terms of movement trust and political reputation, for a feminist women's health organization that shifted its

[42] Anonymous, "F.W.H.C. Response" *off our backs* vol. 4 no. 9 (August-September 1974), 17-20.
[43] Ibid., 21.
[44] Miriam Frank, Carole Kellogg, Cathy LaDuke, Kaye Otter, Connie Conin, Nikki Muller, Mary Jo, Denise Jacques, "Letter to the Editor," *off our backs* vol. 4 no. 9 (August-September 1974), 22; Debbie Freidman, Jackie MacMillan, Chris Murphy, Shirl Smith, Laura Bertran, Lark Prokupek, Juanita Weaver, "Letter to the Editor" *off our backs* vol. 4 no 10 (October 1974), 27. Emphasis in original.
[45] Marla Kaplan, "Letter to the Editors" *off our backs* vol. 4 no. 10 (October 1974), 27.
[46] Sister [Newspaper], "Letter to the Editor" *off our backs* vol. 4 no. 10 (October 1974), 27.

stance on core feminist organizational principles. The Atlanta FWHC's founding mothers were certainly aware of these conflicts and the lasting rancor they could engender.

Yet less than a decade later, they do not appear to have shown any fear that a similar public firestorm would follow their own alterations to feminist process. Nor, as far as the archive is concerned, does it seem they had any reason to. There is literally no mention of it in any of the feminist or Left periodicals surveyed for this project: no trace of it in *off our backs*, nothing in *The Monthly Extract*, and no mention of these changes or of any controversy surrounding them in the archives of two primary Atlanta-based periodicals, alternative newsweekly *The Great Speckled Bird* and the reliably opinionated *Atlanta Lesbian Feminist Association Newsletter*. Six to eight years after and twenty two hundred miles away from the blowup in California, the women of the Atlanta FWHC made even more thoroughgoing and unapologetic alterations to similar feminist ideological and organizational policies without anyone apparently caring much at all.

"People Have to Get Served"

The difference was time and trouble. As the 1970s ground on, feminist health as a movement found itself not only dealing with increasing challenges but also having to grapple with issues of survival as the momentum of newness faded. As Sandra Morgan's research vividly shows, feminist health institutions were, on a day-to-day basis, "like many other health care facilities or small businesses—they had to staff the clinic, provide quality health care, attract clients, interact with the public and other health providers, maintain extensive records, and cope with both the routine and nonroutine pressures of staying afloat."[47] Morgen's 1990 survey of extant women's health organizations revealed that across the board, feminist health organizations that did manage to survive the Reagan years did so by diminishing or abandoning their commitments to precisely the sorts of idealized

[47] Morgen, Into Our Own Hands, 109.

approaches that the outraged former Los Angeles FWHC workers felt should have been their feminist birthright. "Job specialization, hierarchy, and time spent on clerical and administrative work increased for a large majority of respondents," Morgen states.[48] By the early 1990s, almost three-fourths of the organizations Morgen surveyed had directors, seventy-one percent compensated employees based on their job titles and responsibilities, nearly seventy percent were governed by boards of directors, and only a quarter still practiced any form of job rotation.[49] Self-help gynecology had experienced a sharp decline, as had consciousness-raising activities.[50] Perhaps Carol Downer, in her unapologetic defense of hierarchy and structure back in 1974, could be considered not as a traitor to the cause, but merely ahead of her time.

Across the 1980s, Morgen's research establishes, feminist health organizations retreated from the doctrinaire feminist priorities of the 1970s because it simply became more difficult for them to survive what Jennifer Nelson describes as "a rapidly transforming political and social environment."[51] By 1990, Morgen's respondents may have decreased their self-help gynecology and consciousness raising by half and dramatically upped their hierarchical management practices, but by the same token, almost half of them reported increases in the amount of advocacy and legal activity they undertook, "considerable pressure" on their organizations from anti-abortion forces, and nearly all reported some level of pressure from either "the health care establishment" or state and federal agencies to change or reorient their activities, with many organizations experiencing pressure from both those sources.[52]

Viewed in the historical hindsight Morgen's research provides, the AFWHC's shifts of practice and policy are revealed as far more indexical than retrograde. Looking at them through the

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[48] Ibid., 114.
[49] Ibid.
[50] Ibid.
[51] Nelson, More Than Medicine, 125.
[52] Morgen, *Into Our Own Hands,* 114-116.

recollections of the AFWHC founding mothers, in turn, lets us see them at ground level, as the specific functional responses of individual feminist health providers. Doing so allows us to realize, for instance, that at least in the case of some clinics, these changes were not necessarily made with a great deal of attention to ideology or even to the fact that changes were taking place.

For instance, as Lynne Randall explained, no formal decision was undertaken to have her become the AFWHC's executive director and Lynn Thogersen the clinic director. Rather, they gradually became aware that they were functioning in these roles, and then "[S]omewhere between 1980 and 1982," Randall recalled, they decided to formally assume the hierarchy and the titles.[53] Thogersen recalled the shift in greater and different detail:

> "We did move from a collective into a hierarchy. Lynne Randall became the spokesperson for the organization – she was the executive director. The other two founding mothers (Janet and myself) both had kids, so we couldn't do that job. I became the clinic administrator, which I really liked, and Janet became the director of finance and personnel, more out of necessity. The three of us would still meet every week and make decisions as a group, but Lynne Randall was more visible in the community and she represented the health center on a national level."[54]

The archive demonstrates that this pattern of haphazard and reflexive, rather than explicit, ideological, or planned organizational change was fairly consistent at the AFWHC. For example, job rotation was originally an explicit part of the AFWHC's feminist strategy. AFWHC personnel papers detail a job rotation policy expressly intended to enable all workers to know and understand every detail of the labor of the organization from assisting with abortions to washing the floors. They believed this would automatically inform and strengthen the clinic's internal quality control mechanisms, in that each worker would have "more information with which to evaluate her job position and the other healthworkers. …When all of the healthworkers have a common understanding of all the clinic jobs and what goes into each job, this ensures quality of decision-

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[53] Ibid.

[54] Thogersen interview circa 2007.

making and development of procedures and policies."[55] This faded out quickly in light of the realities of the time-consuming nature of job training and the variability of individual aptitudes for particular tasks. It was more effective, in some cases, to "buy those skills, you know, hiring someone who can specifically do that as things get more and more complex."[56]

The difference between those whose specific skills were bought in this way, as opposed to those who essentially volunteered to do whatever needed to be done for the good of the operation, was reflected in the regularity and quantity of pay. Many clinics, again seeking to create a maximally egalitarian workplace, paid all workers the same, whether that was accomplished through profit-sharing or a uniform wage. Lynne Randall recalled that this was never the case at the AFWHC. Those hired specifically to do highly skilled jobs such as bookkeeping were referred to as "regular employees." They were regularly paid at a consistent rate, whereas other members of the collective, very much including Randall and Thogersen, agreed to tolerate not always being paid consistently or at a consistent rate when the AFWHC's finances could not support it.[57] Between 1977 and 1983 there were many times Randall and Thogersen, along with Janet Callum, were paid only a percentage of their slated salaries. Not until 1985, when the AFWHC had finally managed to amass a bit more than $20,000 in their salary fund, would they finally receive their back pay.[58] "Regular employees" were paid in full, in other words, even when the clinic's founders weren't: their specialized labor was seen as both critical and beyond the capacities of the other workers and so they were compensated accordingly. But as "regular employees" they both were, and were not, part of the feminist

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[55] "Rotation of Clinic Jobs ," n.d. Papers of the Atlanta Feminist Women's Health Center, Box 7, folder "Quality Assurance Mechanisms," Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University. While it is unclear whether this policy was authored by the AFWHC or was adopted from another clinic's policy – such as, perhaps, the Los Angeles or Orange County FWHC – the intent of the policy is clear.
[56] Thogersen interview, 2007.
[57] Randall interview circa 2007.
[58] Notes of the Executive Committee Meeting, Atlanta Feminist Women's Health Center, June 19, 1985. Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center.

collective. "Regular employees" were not "as actively involved in the decision-making process," Randall said, because "as a health care provider that there are certain jobs that have to get done."[59] Jennifer Nelson's work on the early AFWHC also reveals two pay-differentiated ranks of health workers within the organization, but it is noteworthy that this was a considerably more formalized policy, as each had a specific job description.[60]

In multiple ways, then, deprofessionalization practices and nonhierarchical structure went by the wayside early in the Center's existence. Thogersen and Randall's memories of the shifts toward more traditional hierarchies and professionalization, however, don't hint at any ideological guilt, nor fear of controversy or censure. Instead, they very distinctly speak of practicalities. In the words of Lynne Randall, "Women are coming in at 9 am and you can't be in meetings all the time, people have to get served and that's one of the realities of being a healthcare provider."[61] Thogersen's recollections second this. Shifting to a more traditional organizational hierarchy, she said, "enabled us to recognize leadership, but also to save time – collective decision-making is very time-consuming."[62]

Revolutionary Project or Consumer Alternative?

Although the demands of running a women's health center certainly offered ample rationales for loosening up or even giving up on some of the more taxing bits of ideologically motivated organizational practice, this was not unique to the AFWHC.[63] As case histories by Sandra Morgen and Jennifer Nelson show, not all feminist health organizations chose to make such shifts. The AFWHC and the Berkeley Women's Health Center, to name just one other organization whose

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[59] Ibid.
[60] Nelson, *More Than Medicine,* 130-131.
[61] Lynne Randall interview, 2007.
[62] Lynn Thogersen interview, 2007.
[63] Morgen, Into Our Own Hands, 77-79.

ideologically-informed organizational practices changed with the times, both eventually yielded to "the ways the consensus-seeking decision-making policies that conformed so perfectly with the theory of the women's health movement but that hampered practice" and gave up on collectivity in the name of institutional functioning.[64] Other organizations like the ill-fated Cambridge, Massachusetts Women's Community Health Center chose paths that ultimately killed the organization, but allowed it to maintain its core ideological identity "as an institution of social change."[65]

The extent to which feminist health organizations viewed themselves as social change agents, as purely health care providers, or as somewhere on a spectrum between the two is an issue that has yet to be assayed in the literature. On the basis of extant case studies, however, it seems to have significant influence on institutional outcomes. The evidence simply does not support the idea that all feminist health organizations shared a uniform self-concept or set of goals. While all of them prioritized health care for women, and most of them prioritized health care for women that was created, managed, and where possible provided by women, their agendas otherwise rarely matched point for point. The questions of what an organization was attempting to create and provide for other women and for the larger community and world could be, and were, answerable in many ways.

Feminism, of course, is emphatically not monolithic. As with all other political movements too, to say nothing of religious ones, feminists have always manifested in a range of levels of ideological purism and commitment, from the fair-weather to the fundamentalist. Historians of feminism, to say nothing of feminist historians, have wrestled with the problem of how to categorize feminisms and approaches to feminisms ever since the nineteenth century. The liberal versus radical and large-group versus small-group models of historians like Jo Freeman, Alice Echols, and Ruth

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[64] Ibid., 84-85.
[65] Ibid., 99.

Rosen each proved useful to some in their various ways; the "feminist waves" metaphor continues to crash against the shore of laterally expansive scholarship by Nancy Hewitt and others.[66] These large movement analytics have also encountered the complications of studies focused on grassroots, rather than national, manifestations of feminism such as those by Anne Valk, Judith Ezekiel, and Stephanie Gilmore.[67] Work on women-of-color and Black feminisms, including work with specific resonance to the women's health movement like Jennifer Nelson's *Women of Color and the Reproductive Rights Movement*, added even more specificities and subjectivities to the historiographical cauldron.[68] Increasingly, too, there are regionalist studies such as Jaime Harker's *The Lesbian South: Southern Feminists, the Women in Print Movement, and the Queer Literary Canon*, whose explorations of the influences of shared geographically-linked sociocultural heritage on feminist activity challenge blanket categorizations of feminism yet further.[69]

So too it seems reasonable to assess the degree to which there were, and perhaps still are, multiple camps among feminist health organizers and organizations. Although my assessment is necessarily at this point quite preliminary and my scope limited by the nature of this project, it seems nevertheless reasonable based on available evidence to identify a few broad approaches among health feminist organizations. There are those groups, such as the previously mentioned Cambridge, Massachusetts Women's Community Health Center and the National Black Women's Health Project, that considered feminist health to be a revolutionary action that if done properly could and

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66 Alice Echols, Daring to be Bad: Radical Feminism in America, 1967-1975 (Minneapolis: University of Minnesota Press, 1989); Jo Freeman, The Politics of Women's Liberation: A Case Study of an Emerging Social Movement and its Relation to the Policy Process (New York: Longman, 1975); Ruth Rosen, The World Split Open: How the Modern Women's Movement Changed America (New York: Viking, 2000); Nancy A. Hewitt, ed. No Permanent Waves: Recasting Histories of U.S. Feminism (New Brunswick, NJ: Rutgers University Press, 2010).

67 Judith Ezekiel, *Feminism in the* Heartland (Columbus: Ohio State University Press, 2002); Stephanie Gilmore, *Groundswell: Grassroots Feminist Activism in Postwar* America (New York: Routledge, 2013); Anne Valk, *Radical Sisters: Second-Wave Feminism and Black Liberation in Washington, D.C.* (Urbana, IL: University of Illinois Press, 2010).

68 Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003).

69 Jaime Harker, The Lesbian South: Southern Feminists, the Women in Print Movement, and the Queer Literary Canon (Chapel Hill: University of North Carolina Press, 2018).

would radically transform both women and society. There are those like the Mari Spehar Health Education Project, who approached feminist health in fundamentally reformist, progressive, and educational ways to help spur awareness and growth of woman-centered healthcare. Some, like the Atlanta FWHC, seem to have been oriented primarily toward service provision, with the style of that service provision shaped and supported by feminist principle. There are also feminist or woman-oriented providers, such as Priscilla Chism, who appear to have viewed feminist clinics primarily as a consumer alternative, one of many types of healthcare options that should be available in the broader marketplace, without necessarily having a strong sense of politicization. This notion of goal-orientation categories is better conceived of as a large and colorful Venn diagram than as a graph or even a spectrum; areas of overlap between organizational orientations were (and perhaps still are) common among groups in the feminist health movement. It is also something that must be conceived of as existing along the axis of time: organizational goals, tactics, approaches, and responses to internal and external stimuli, as Sandra Morgen's survey and oral history work proves, frequently change over time.[70]

Where the archive provides sufficient evidence, then, the historian may wish to assay a characterization of institutional goal orientation, and further, to consider the ways in which different goal orientations might predispose toward particular types of organizational, political, and methodological change. In the specific case of the AFWHC's goals, the creation of a feminist option for women's healthcare seems to have been paramount. Their experience in running Self-Help exam groups helped them to realize that there was no clinical presence in Atlanta to which they felt comfortable referring Self-Helpers. As Lynne Randall recollected, "the feminist women's health center started as a group of consumers who were upset with what healthcare options were."[71]

70 Morgen *Into Our Own Hands*, 109-119, 153-180.
71 Randall interview, circa 2007.

That this was to be a woman-centric and philosophically feminist clinical presence was equally clear to the founders. Lynne Thogersen defined "feminist health center" as "owned by women and run by women and it provides nice comprehensive health care to ALL women. This includes thinking about ALL women nationally and internationally."[72] At most, feminism went hand in hand with creating health care access. It did not precede or exceed the process of creating something that "provides nice comprehensive health care."

Another way to evaluate the AFWHC's political and ideological positionality is to consider it in comparison with Planned Parenthood of Atlanta, an organization with which the AFWHC had some low-key struggles in its early years. At the time the AFWHC opened for business, Planned Parenthood's Atlanta clinic did not provide abortion services, although they did provide pregnancy testing and other services. Planned Parenthood patients who desired abortions were referred out to unaffiliated local abortion providers, of which Planned Parenthood kept a list. During the year following the AFWHC's opening, the staff felt that they were not receiving very many referrals from Planned Parenthood, a low enough number that they wondered whether perhaps Planned Parenthood was in some way biased against them or saw them as unwelcome competitors.

Having given Planned Parenthood a tour of the clinic to establish themselves on Planned Parenthood's abortion referral list, the AFWHC contacted Planned Parenthood with this concern, which was firmly refuted in a July 10, 1980 letter from Kay Bard, Executive Director of Planned Parenthood of Atlanta.[73] Planned Parenthood, Bard explained, had received "calls from several abortion providers" curious about their status on Planned Parenthood's referral list. She emphasized that Planned Parenthood alphabetized the list "to rule out favoritism" and claimed that

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[72] Thogersen interview, circa 2007.

[73] Letter from Lynn Thogersen, co-director of the Atlanta Feminist Women's Health Center, October 15, 1979, to Ms. Sylvia Freedman, Planned Parenthood Atlanta; Letter from Kay Bard, Executive Director of Planned Parenthood Atlanta, July 10, 1980. Box 3, folder "Planned Parenthood", Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

if a client "needs and requests a referral for an abortion procedure she is given the names of three providers."

Bard's letter, however, held no hint that Planned Parenthood saw itself as having any specific allegiance to feminist clinics, for example preferring them over non-feminist or for-profit abortion providers. Rather, Planned Parenthood Atlanta appears to have seen itself as a component – perhaps the central component – of a much broader "reproductive health care movement": "We do not have any vested interest in the success or failure of any provider and to suggest this is demeaning to our organization and ultimately to the reproductive health care movement."[74] Whether either Bard or Planned Parenthood more generally perceived "the reproductive health care movement" as being a location of explicitly feminist politicization, or in what way(s) if so, is unclear.

The AFWHC, on the other hand, definitively saw itself as both politicized and feminist: it was in the name. Looking back on this interaction with Planned Parenthood, Lynn Thogersen articulated her awareness of the political and clinical differences between the organizations.

> "At the tip of the iceberg, we look like we're doing the same work, but there's a murkier level that is still sort of transparent – you can see that the FHC is run and owned by the women who work there, whereas Planned Parenthood is a national chain. When you get down to the bottom of it, our centers are about revolution, about women controlling their life by controlling their reproduction, whereas Planned Parenthood is essentially for population control."[75]

The historian, therefore, is left to ponder the effects of these differences, both from outside the broader women's and reproductive health movement and from within it. From the outside, it would be easy to view Planned Parenthood and AFWHC as doing roughly the same things (providing sexual/reproductive health care, fertility control, and counseling) and sharing roughly the same agenda (enabling women's access to these things). From the inside, however, Planned Parenthood's

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[74] Letter from Kay Bard, Executive Director of Planned Parenthood Atlanta, July 10, 1980. Box 3, folder "Planned Parenthood", Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.
[75] Lynn Thogersen interviewed by Hanne Blank, March 2016.

territory fell well into the conservative, nationally franchised, "establishment" zones of public health and population control politics, while the AFWHC was solidly in a position where health care "by women, for women" at the local and grassroots level still constituted a "revolutionary" stance. The AFWHC, then, was somewhere to the left of Planned Parenthood, but not so far to the left as other feminist clinics; the AFWHC promoted service provision over politics more than, say, the (Cambridge) Women's Community Health Center, but not more than Planned Parenthood or for-profit, non-feminist gynecologists or abortion care providers.

Similarly, we can see some evidence of this political positionality in the AFWHC's apparent reluctance to take major risks, particularly risks that might antagonize the medical and legal establishments. This is a conclusion we can draw on the basis of the AFWHC having had what appear to be relatively friendly relationships with regional doctors, state regulators and inspectors, and indeed Planned Parenthood, by contrast to some of their other feminist health sisters.

Carol Downer, for example, seemed to relish a good tussle with the state in the name of feminist health ideologies and practices. She and others at the Los Angeles Feminist Women's Health Care had a famously antagonistic relationship with the law and the state. Downer and another activist, Colleen Wilson, were arrested in 1972 in what became known as The Great Yogurt Conspiracy, in which a sting operation caught Downer spooning plain unsweetened yogurt (a common home remedy for vaginal yeast infections) into the vagina of another woman during a Self-Help clinic.[76] She and Wilson were charged with practicing medicine without a license. They were ultimately exonerated after they proved more than willing, as well as able, to fight the charges. This would not be Downer's only voluntary tangle with the law in the name of feminist health. She would also be arrested in 1977, in the aftermath of a staged hospital maternity ward inspection

[76] Ruzek, The Women's Health Movement, 57-58.

action undertaken with a number of other feminist women's health activists in Gainesville, Florida.[77] This contributed to Downer's reputation as a ferocious, ideologically driven health feminist, unafraid to face the police or the courts if it advanced the cause.

The AFWHC's approaches were far more moderate and in fact downright ordinary. AFWHC frequently lobbied legislators and gave evidence in hearings against creating legal impediments to their activities whether licensure requirements or parental notification laws (and indeed continues to do so), there is also evidence that regulators did not seem to target the AFWHC in overtly punitive ways. Where the AFWHC did experience conflict with state lobbyists, for instance in their lobbying against a set of proposed 1979 licensure requirements for ambulatory surgical treatment centers (a category that includes abortion providing clinics), their self-representation was not out of keeping with what any other ambulatory surgical center might have done in order to avoid expensive remodeling and retrofitting.[78]

While some other feminist clinics' similarly basic attempts to negotiate business concerns – the Tallahassee Feminist Women's Health Center's, for example – went horribly, creating massive personal and legal conflict, the AFWHC seems to have had a good working relationship with both physicians and the state. An excellent example is an interaction that took place with an official of the Office of Standards and Licensure, Georgia Department of Human Resources, in June of 1980. Lynn Randall made extensive notes on a phone conversation she had with the Office of Standards and Licensure's Rhett Paul.[79] During the call, they discussed laws regarding dispensing prescription drugs. Drug dispensing laws had recently changed to require all prescription pharmaceuticals to be

[77] Ibid., 167-168.

[78] Untitled notes. [n.d.] Box 7, Folder "Clinic Regs," Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

[79] Lynn Randall, "Notes on Phone Conversation with Rhett Paul, Office of Standards and Licensure, DHR," June 18, 1980. Box 7, Folder "Clinic Regs," Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

dispensed in child-proof containers with individualized labels naming drug, dosage, prescribing physician, and patient. For reasons of expense and convenience, however, the AFWHC had continued in its old method of using plain paper envelopes to dispense a commonly-used generic post-abortion drug protocol of Methergine (reduces chances of uterine hemorrhage), Darvon (analgesic), and Tetracycline (antibiotic). During their call, Paul repeatedly told Randall to "stay out of dispensing" and additionally assured Randall that "he knows we don't do this" to which Randall added, parenthetically, "(not knowing that we do)."[80] Had the AFWHC been caught dispensing drugs in their customary manner, the consequences could have been serious, possibly serious enough to jeopardize the future of the organization. Whether Paul said what he did out of ignorance or as a compassionate little white advisory lie that would allow the AFWHC time to bring its practices into compliance, his statements in this conversation indicate an overwhelmingly supportive and approving attitude toward the AFWHC that imply no ill will or adversity between the Center and the state.

This might have gone otherwise. Had the AFWHC chosen to invest more in an ideology of overturning patriarchal control (over women's access to prescription drugs in this case) by continuing to allow laywomen to dispense medications to other women, things could rapidly have gotten ugly and endangered the future of the AFWHC. Instead, the AFWHC chose to modify their methods to suit the requirements of the system, by definition an assimilationist move and one by which the AFWHC signaled a moderate, centrist feminism and a service-driven professional ethos.

It seems clear that the AFWHC thought of itself as more than simply another consumer option, however: it was by women, for women, and overtly feminist. Yet at the same time, in its interactions with the public, the why and how of ideology and policy took a decided back seat to what they *provided.* In the minds and hearts of its staffers and volunteers, the AFWHC's feminism

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[80] Ibid.

was important, and a crucial distinction that separated it both from organizations like Planned Parenthood and from for-profit privately owned abortion clinics. For the majority of its clients, however, what brought them through the clinic doors was not the AFWHC's politics, but instead the accessibility, cost, and quality of care it offered. As Lynne Randall put it, "There's always a conflict inherent in trying to take an idea and have a successful business. So while we were focused on a feminist goal, we also were acutely aware that we're providing healthcare to women and we have to do that impeccably well."[81] This approach, and this attitude toward ideology, places the AFWHC somewhere in between the "consumer alternative" and "revolutionary project" models of alternative health care. This middle ground appears to have been both effective and protective. An ideologically moderate, politically centrist stance allowed the AFWHC to change as needed in order to continue to provide services even as the national and regional political climates began to change from the relatively left-leaning liberality of the Carter 1970s to the creeping neoliberalism and religiously-rooted rightward motion of the Reagan 1980s.

Of Antagonists, Audits, and Amendments

In 1979, two years after the Atlanta Feminist Women's Health Center opened, Newton Leroy Gingrich, a sturdily right-leaning Georgia Republican who would eventually become the 50th Speaker of the United States House of Representatives, took office as a Congressional representative from Georgia's 6th district. Gingrich's election was part of the slow turn away from the previously entrenched conservative Democratic "Solid South," and he would be re-elected six times in his district, which encompassed a large part of Atlanta's wealthy and expansive northern suburbs. As part of a groundbreaking brand of coalition-building conservative politics that established Gingrich as a key figure of the "Republican Revolution" in the south, Gingrich forged strong ties with a range

[81] Randall interview, 2007.

of conservatives including those in the anti-abortion movement.[82] In concert with some of these conservatives, Gingrich took a gambit from Richard Nixon's playbook: the use of the Internal Revenue Service audits as a tool for repression. Notoriously, in 1971, Nixon had attempted to find a new commissioner of internal revenue who would be "a ruthless son of a bitch…that every income tax return I want to see, that he will go after our enemies and not go after our friends."[83]

Nixon failed in this attempt, thwarted by former IRS chief Johnnie Mac Walters, but the strategy and its implications would not be forgotten.[84] The AFWHC's Lynn Thogersen recalls that together, Gingrich and local Atlanta conservatives helped to target small, independently-run abortion providing organizations with not-for-profit, 501[c][3] tax status for Internal Revenue Service audits: as Lynn Thogersen later said, "they knew they couldn't start by taking on Planned Parenthood."[85] One of the organizations chosen for this treatment was the Atlanta Feminist Women's Health Center, the visibly feminist and independently run – and therefore politically vulnerable – abortion-providing clinic near his home district.[86]

Fortunately, the AFWHC had experienced this before, within just a few months of the clinic opening. Advised by other clinics who were justly wary of the potential damage, to say nothing of the disruption, of an audit, the AFWHC had been careful recordkeepers who did everything by the book. Thus they emerged from the first audit unscathed. They did so the second time as well, thus

[82] Matthew D. Lassiter, "Big Government and Family Values: Political Culture in the Metropolitan Sunbelt" in Michelle Nickerson and Darren Dochuk, eds., *Sunbelt Rising: The Politics of Space, Place, and Region* (Philadelphia: University of Pennsylvania Press, 2011) 82-86, 103-106.
[83] George Lardner, "Nixon Sought 'Ruthless' Chief to 'Do What he's Told' at IRS," *Washington Post* (January 3, 1997). https://www.washingtonpost.com/archive/politics/1997/01/03/nixon-sought-ruthless-chief-to-do-what-hes-told-at-irs/6a9dbd0a-0261-4afe-9402-21b154bb20bd/?utm_term=.acf83f14de44, Accessed 10/15/2018.
[84] Douglas Martin, "Johnnie M. Walters, I.R.S. Chief Who Resisted Nixon's Pressure, Dies at 94," *New York Times* (June 26, 2014). https://www.nytimes.com/2014/06/26/us/politics/johnnie-m-walters-ex-irs-chief-dies-at-94.html, accessed January 16, 2019.
[85] Thogersen interview, 2007; Thogersen interview, 2016.
[86] Thogersen interview, 2007; Thogersen interview, 2016.

thwarting the anti-abortion movement's ambitions and retaining their not-for-profit tax status, which was both economically and politically crucial to the AFWHC's operations.

Their success, however, was not without its price. Any tax audit takes time and staff resources, not only for the audit itself but for all the preparation and documentation that precedes the audit. Audits are notoriously stressful for anyone who must undergo one, and audits for grassroots not-for-profit groups doubly so, given that organizational viability could rest on the result. The use of tax audits as a tool of state harassment is not so unlike the use of, for example, punitively punctilious inspections, deliberate shifts in clinic staffing regulations, or a shift in the legal width of clinic hallways to one that would allow two hospital gurneys to pass, all of which have been among the strategies of anti-abortion legislators for years.[87] The object of such state interventions is that small and independent clinics will be unable, usually due to finances, to conform and will thus be forced to close. Such state attempts to challenge or eradicate the presence of reproductive health organizations, and particularly abortion providers, are part of the hidden challenges—and the hidden overhead—of providing reproductive and/or abortion healthcare. Feminist clinics, due in part to their independence from larger institutions and their tendency to resist capitalist business models, tend to have less capital with which to resist or reply to such challenges.[88] Since the repeal of the 18th Amendment in 1933 allowed the full resurgence of a legal alcohol industry, there have been no other business sectors, save possibly for the pornography industry, that have consistently experienced both organized civilian and state attempts to eradicate them. I cannot think of another nationally legal industry in the United States that faces such consistent and high-level attempts to destroy it. Resisting this continual onslaught requires time, money, and energy as well as

[87] Kate Sheppard, "Virginia's Abortion Crackdown," *Mother Jones* (February 24, 2011). https://www.motherjones.com/politics/2011/02/va-regulate-abortion-clinics-hospitals/, accessed January 16, 2019.

[88] Morgen, Into Our Own Hands, 190.

commitment, and while the staff of feminist women's health clinics historically have a great deal of the last, the former are in much more limited supply.

This is why it is crucial to consider the role(s) that this need for ongoing self-defense may have played in the AFWHC's centralizing organizational shifts. AFWHC founding mothers clearly identified operational pragmatism as one of their reasons for abandoning highly ideological methods and practices; Randall's "people have to get served" is an unimpeachable statement of fact. But a cursory examination of some of the larger legislative obstacles and threats the AFWHC faced shows that the factors diminishing the Center's ability to serve its public were not limited to the hours-long consensus meetings, job rotation learning curves, and other obstacles generated from within. A national anti-abortion movement, formed even before *Roe v. Wade* in 1973, posed increasingly obstructive legislative and activist opposition.[89] On June 28, 1976, roughly six months before the AFWHC opened its doors, the U.S. House of Representatives passed the so-called "Hyde Amendment." Sponsored by Illinois Republican Henry Hyde, this amendment to the Department of Health and Human Services appropriations bill prohibited the use of Medicaid funding for abortion barring a few exceptional circumstances known in the reproductive health field as PRIM – *P*renatal health, *R*ape, *I*ncest, or the health of the *M*other.[90] As dozens of photos in the AFWHC archive show, the organization came to life in the midst of a swirl of anti-Hyde protests, condemning the legislation for its insistence on recapitulating the pre-*Roe* state of affairs in which poor women had the greatest difficulty obtaining a safe (let alone legal) abortion.[91]

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[89] The organization "National Right to Life" was formed in 1968, and incorporated as a 501[c][4] organization in May of 1973, four months after the passage of *Roe v.* Wade. National Right to Life, "Abortion History Timeline" http://www.nrlc.org/abortion/history/, accessed 22 September 2018.
[90] Rebecca Todd Peters, Trust Women: A Progressive Christian Argument for Reproductive Justice (Boston: Beacon Press, 2018) 4-5, 141-144.
[91] Photographs in the Papers of the Atlanta Feminist Women's Health Center. Private Collection, Atlanta Feminist Women's Health Center

Within the first ten years of the AFWHC's existence, it had a great deal of legislative opposition to negotiate, ranging national matters like the Hyde Amendment, to state-level attempts to rewrite licensure requirements in ways that threatened to squeeze out smaller and not-for-profit clinics in favor of providers with greater access to medical industry funding and resources.[92] Attending legislative sessions, lobbying representatives, representing the Center at community events like marches and rallies, and doing outreach to enable AFWHC supporters to help with these efforts and their funding became additional tasks the Center had to add to its already overwhelming workload. The AFWHC, already a member of the Federation of Feminist Women's Health Centers, joined other professional organizations like the National Abortion Rights Action League (now known as NARAL Pro-Choice America) and its Georgia chapter GARAL, the National Abortion Foundation (NAF), and the American Public Health Association, all of which worked to combat initiatives attacking abortion providers. There was, however, no easy fix. Responding to opposition and working to legally and socially defend reproductive health liberties for women was an irreducible necessity. Engaging in this political work took time and resources, regardless of the level at which the AFWHC engaged in more strictly feminist ideological work.[93]

The AFWHC was also increasingly forced to defend itself and its clientele more literally. At times the assault was procedural, and had to do with ongoing attempts to challenge independent abortion providers by instituting increasing demands on ambulatory surgery centers. Correspondence dating between 1977 and 1980, for example, details the AFWHC being challenged by the Atlanta Ob-Gyn Society of the Medical Association of Atlanta in regard to the clinic having

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[92] Box 7, folders "Regulation Application" and "Clinic Regs." Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

[93] Annual Meeting Notes, Atlanta Feminist Women's Health Center, March 29, 1978. Box 17, Folder "Annual Meeting, 1978." Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

what they felt was "appropriate"—and expensive—cardiac emergency equipment on hand.[94] The Medical Association of Atlanta representative responded to repeated AFWHC explanations of why cardiac emergency equipment was unnecessary and impractical for their clinic with a brisk, dismissive "our referrals for abortions will therefore be limited to those patients who seem to share your philosophy of health care or those who need the special emotional support we think your staff provides."[95] These kinds of sanctions and threats could have a significant impact on the AFWHC's business, and so the AFWHC ultimately gave in and went to the expense to acquire the equipment in question, install it, and train their staff and practitioners in its use.[96]

These types of quiet pressures designed to make life difficult for independent healthcare providers as well as abortion providers, undramatic as they were, cost money, time, and aggravation. Other types of pressures, of course, were noisier, far more public, and much more frightening. As anti-abortion politics grew more heated, the AFWHC began to have difficulty finding and keeping physicians and staff. They had to contend with bomb threats, picketers, vandalism, harassment of staff and doctors, death threats, and more. During the Democratic National Convention held in Atlanta in 1988, Operation Rescue blockaded the clinic. Although the clinic had some warning that this was planned and was able to meet with police to discuss how to handle it, little could have really prepared them for the 20-day siege during which over 1300 anti-abortion protesters were arrested. As the 1989 Executive Directors' Report put it, "20 days does not begin to describe the months of siege, of constant preparedness, and anxiety," nor does it hint at the approximate $100,000 in lost business and direct expenses (exclusive of later legal expenses that continued with prosecutions).[97]

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[94] Alton V. Hallum, Jr., to Lynn Randall. November 16, 1977. Box 101. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.
[95] Philip R. Bartholomew to Lynn Randall, February 21, 1980. Box 101. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.
[96] Philip R. Bartholomew to Lynn Randall, February 29, 1980. Box 101. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.
[97] Executive Director's Report, 1998. Box 56. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

The following year, the IRS performed "a very thorough two-month audit" of the AFWHC that the Executive Director suggested "was driven by complaints by Operation Rescue," which did not "want to believe an abortion clinic would operate on a non-profit basis, since it contradicts their propaganda about abortion providers being rich exploiters of women, and because dealing with the IRS is time-consuming and expensive, we believe this financial harassment is another tactic in their efforts to shut us down."[98] After extensive review that included the implicit question of whether "providing abortion care qualifies as a 'medical service'," the IRS finally dropped the challenge.[99]

The harassment did not end there. A few paragraphs from the 1990 Executive Director's Report depict it well:

> "On the first business day in January, we found a suspicious package on our doorstep and called the bomb squad to take it away. The next day, 16 people were arrested for blocking our doors. The third business day, we received a series of bomb threats. And so our year started….
>
> Several times the locks on the clinic doors were glued shut. Our clients and staff faced anti-abortion harassment 18 out of the 27 days we were open in March, and on one occasion, anti-abortion demonstrators, posing as clients, entered the clinic and managed to disrupt the waiting room and counseling room. Another time, five men blocked our front door.
>
> In April, Judge Jenrette granted a permanent injunction against Operation Rescue, mandating they stay at least 50 feet from the clinic. …The homes of our physicians, in Atlanta and as far away as Cairo, Georgia, continued to be picketed by anti-abortion protestors."[100]

All of this, not to mention the regular presence of leaflets and flyers characterizing the AFWHC as an abbatoir, a brothel, and a lesbian den of iniquity, absorbed at least some of the clinic's resources. So too did some frightening anti-abortion stalkers and wildcat solo litigants, whose vituperative and violent (to say nothing of vile) threats to the clinic may have inspired incredulity—

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[98] Executive Director's Report, 1989. Box 56. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.
[99] Ibid.
[100] Executive Director's Report, 1990. Box 56. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

one such litigant attempted a Sherman Act anti-trust lawsuit on the grounds that abortion providers including the AFWHC were harming his (putative) business as a children's toy manufacturer, another posted flyers claiming that among other sins, the AFWHC used "members of Satanic Cults as escorts"—but also required time, money, energy, and sanity to deal with.[101] [102]

Ridiculous threats could be just as draining, in other words, as credible ones, and almost as resource-intensive for the clinic to handle as glued-shut locks, picketers showing up at staffers' homes, or protesters shouting loudly enough to be heard inside the clinic. Clearly the AFWHC did not have to go down a heavily radical-feminist ideological path in order to maintain a presence that drew a radical right-wing opposition, and to do so would not have improved the clinic's chances of surviving.

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It is historically clear that the Reagan 1980s represented a time of significant retreat for radical feminist ideals and community, as well as an era of decline for the feminist women's health

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[101] Mitchell Williams v. United States Postal Service, Grady Hospital, Northside Hospital, Shallowford Hospital, Reproductive Biology Associates, Inc., Midtown Hospital, Inc., Bell South Corporation, Atlanta Coca-Cola Bottling Co. Inc., Planned Parenthood, Feminist Women's Health Center, Inc., Tom Teepen, Atlanta Surgi-Center, Inc., Northside Family Planning Service, Inc., and Georgia Power Company, Inc. C86-1145A. Box 49. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University. The plaintiff in this case also demanded "that the Plaintiff receive a standing ovation from the Court for his incredible performance in this case without formal legal training" and "that the Court recommend to the President of the United States that the Plaintiff be awarded the Medal of Freedom… for singlehandedly dropping the Human Life Bomb on the abortion industry in the United States."

[102] The Spirit of "76", "The Feminist Women's Death Center." Box 19. Papers of the Atlanta Feminist Women's Health Center, Sallie Bingham Center for Women's History and Culture, Duke University.

movement.[103] Legislative threats to the core activities of feminist women's health went hand in hand with the rising tide of the religious and neoliberal Republican-identified right; it became less and less easy as well as less feasible for feminists to live by the ideals of the previous decades.[104] A retreat from the ideological vanguard in favor of managerial and organizational methods that would be legible and less threatening to the state and other representatives of the established order was therefore pragmatic, a survival strategy on more than one level: no war can be effectively fought when it is spread over too many fronts.

Born somewhat later than many of its sister clinics, the Atlanta Feminist Women's Health Center had the hallmarks of an "end of an era" organization in that it inherited much from its predecessors, only to almost immediately face challenges neither it nor its predecessors had yet negotiated. This helps make sense of why, when it came to realizing the leftist feminist organizational goals it had inherited, the AFWHC was not a success and in fact made no concerted attempt to be. For them, feminism supported their identity as clinical providers, not the other way around. Revolution, if it arrived, would be a byproduct of their ability to maintain a feminist health presence. Pragmatic, indeed.

The South, Rising Again?

It could be argued that this had little to do with region, and that that the creeping conservatism of the Reagan years was the predictable pendulum swing after the notably liberal-leaning Carter era. But there is one way in which a consideration of regional politics, not just national trends, bears

[103] See especially Morgen's Chapter 8, "The Three Rs: Reagan, Retrenchment, and Operation Rescue in the 1980." Morgen, *Into Our Own Hands,* 181-205.
[104] David Domke and Kevin Coe, *The God Strategy: How Religion Became a Political Weapon in America* (New York: Oxford University Press, 2008) 18-22.

fruit: the rise of Reagan is coterminous and in some ways coextensive with the rise of the so-called "Sunbelt," the political resurgence of the southern tier of U.S. states. As historian Darren Dochuk discusses in his *From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism*, the conservative nature of the eventual Sunbelt had a great deal to do with southern migration patterns to the west. As the Sunbelt rose in prominence, it was not, as was frequently imagined, an essentially western political orientation that rose with it, but a hybrid of west and south, rooted deeply in southern protestant Christianity and nostalgia for an imagined simpler, better, and more moral time.[105]

The rise to national prominence of the Sunbelt and its sociopolitical ideologies, then, can be viewed in part as a movement of aspects of southern thought and sentiment onto the national stage, connected and tethered – by Newt Gingrich as mentioned, but also politically prominent protestant clergy like Jerry Falwell (Lynchburg, VA) and Billy Graham (Charleston, SC) – to the geographic southeast. In light of the ways that the AFWHC presents a virtual *locus classicus* of feminist health clinic formation and retrenchment, it is impossible to justify characterizing it as being "distinctively southern," yet there are ways in which a phenomenon that can be and has been shown to have intrinsic connections to the south can be said to have shaped the actions and reactions of the AFWHC. "[W]e were under a lot of scrutiny," as Lynn Thogerson said in 2007, "and so it felt good to adopt a more traditional non-profit structure."[106] Considering the rise of Southern conservatism and specifically its Atlanta-area manifestations (e.g. in Gingrich's Cobb County), to adopt this sort of organizational protective coloration was certainly pragmatic, and in far more ways than the women of the Atlanta Feminist Women's Health Center may have realized at the time.

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[105] Darren Dochuk, From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism (New York: W.W. Norton & Company, 2011), xv-xvii, 9, 16-17, 345-353, 383-395.
[106] Thogersen interview 2007.

Afterword

In the historiography of the feminist women's health movement there is one point on which its chroniclers unequivocally agree: the feminist women's health movement, coupled with the larger feminist movement, Civil Rights, and other streams of cultural change during the period between 1960 and the mid-1990s, was a tremendously form-conferring, deeply transformative influence on the United States' expectations and practices of medicine. The rights of the patient expanded dramatically, including better and more universal consent models, dramatically higher standards of patient education, broader awareness of social determinants of health, and a burgeoning culture of participatory healthcare in which patients were reimagined as active partners in their own health rather than passive objects of medical attention. As Gillian Einstein and Margrit Shildrick put it, "The practice of women's health is now woven into the mainstream of traditional medicine. From its early origins in self-care and the de-pathologizing of women's bodies, the practice of women's health has grown to be a major sector of the health care industry".[1]

Women practitioners, too, abound in today's medical industry. Thanks both to the larger feminist push for employment equity and women's access to professional education and to the expectations cultivated by the feminist women's health movement that women should be the authorities over women's health and women should have the option of being examined and treated by other women, women obstetrician-gynecologists represented more than half of all obstetrician-gynecologists as of 2017.[2] The American College of Obstetricians and Gynecologists expects that women will comprise fully two-thirds of the obstetric-gynecological physician pool by 2022. Not

[1] Gillian Einstein and Margrit Shildrick, "The Postconventional Body: Retheorising Women's Health" *Social Science and Medicine* 69 (2009), 293.
[2] William F. Rayburn, *The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications, 2017* (Washington, D.C.: The American College of Obstetricians and Gynecologists, 2017), 11.

only are women physicians now in the majority in the only medical specialty that exclusively treats adult women (and other adults assigned female at birth), they have brought with them other artifacts of the feminist women's health movement that provide evidence of the ongoing influence of feminist models of care. An excellent example of this is the warming drawer now available as a built-in feature in a wide variety of gynecological examination tables, put there in order to warm speculums and other tools for the sake of the comfort of the patient undergoing an examination. Without the feminist health movement's emphasis on the importance of patient experience and the authority of women's experiential knowledge of their own bodies, it is unlikely that this tiny addition to the clinical built environment would have been innovated. The presence of a simple warming drawer speaks volumes.

The gynecological exam tool warming drawer, too, represents one way in which the priorities of feminist women's health have been internalized by the larger mainstream medical industry in the United States. The influence of feminist health ideas and ideologies is demonstrably far larger and more sweeping than the presence of feminist health groups and institutions themselves, to the point where since the 1970s, mainstream cooption of certain aspects of health feminism has become routine. Among the forms of cooption was the development of hospital-based women's health centers, often dedicated to the traditional "women's medicine" of obstetrics and gynecology, but also, with the emergence of "women's specialties," also to practices of cancer, heart, and bone care for women.[3] Women demonstrably wanted, and have heavily utilized, these "women's clinics." As early as 1994, three researchers at the Johns Hopkins University School of Hygiene and Public Health Department of Health Policy and Management authored a national survey of women's health centers to assess current models of women-centered care. Noting that "The hospital-sponsored women's health centers… are a new option for women's health care—midway between separate

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[3] Einstein and Shildrick, 293.

women's institutions and assimilation of women's health care into general health services. …As women-centered (though not women-controlled) alternatives within mainstream institutions, hospital-sponsored women's health centers may be able to provide both a therapeutic milieu tailored to women and access to the resources of the parent organization."[4]

Feminist criticism of such cooption grew along with the cooption itself. Although feminists were often angry about what they perceived as an appropriative agenda in the name of profit-making on the part of hospitals, there was little they could do about it.[5] Simultaneously, at least some feminists acknowledged (if grudgingly) that when mainstream cooption becomes a problem for an activist movement, it was a sign of a certain level of successful cultural change.[6] The first generation of criticism about what we now call "pinkwashing"—the for-profit appropriation of grassroots women's health initiatives, e.g. the wearing of a pink ribbon as public remembrance of breast cancer patients—was critique of this shift in the meaning of "women's health" away from the feminist women's health movement and into a fundamentally non-feminist, non-politicized mainstream medical industry.[7]

All of this is why it is crucial that our understanding of American medical and health history writ large include a critical, nuanced, and reasonably comprehensive understanding of the feminist women's health movement. Without the feminist women's health movement, it is unlikely that the U.S. health landscape would have been so thoroughly terraformed—a word I use advisedly, as it implies the alteration of an hostile alien landscape into one that is capable of supporting and

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[4] Barbara Crubow, Amal J. Khoury, and Carol S. Weisman, "The National Survey of Women's Health Centers: Models of Women-Centered Care" *Women's Health Issues* 5 issue 3 (1995), 116.
[5] Nancy Worcester and Mariamne H. Whatley, "The Response of the Health Care System to the Women's Health Movement: The Selling of Women's Health Centers" in Sue Vilhauer Rosser, ed., *Feminism Within the Science and Health Care Profession: Overcoming Resistance* (Oxford: Pergamon Press, 1988).
[6] Sandra Morgen and Alice P. Julier, *Women's Health Movement Organizations: Two Decades of Struggle and Change* (Eugene, OR: University of Oregon, Center for the Study of Women in Society, 1991).
[7] Meg Carter, "Backlash Against "Pinkwashing" of Breast Cancer Awareness Campaigns" *BMJ* (2015), 351. doi: https://doi-org.proxy.library.emory.edu/10.1136/bmj.h5399 accessed November 13, 2018.

including human life. And without a feminist women's health movement as far-reaching and well-distributed as the U.S. movement appears to have been, it seems as unlikely that its influences would have been so broadly and significantly felt in the American medical industry as a whole.

As historians we cannot, in other words, rest so easily on the tacit assertion that feminist women's health activity existed primarily, or even merely in its most important manifestations, along the northern and coastal edges of the landmass. To do so does not give the movement as a whole its due, for one thing: a national movement is not national if it exists only in urban and urbane pockets. But nor does a geographically limited understanding of feminist health organizing adequately explain the degree to which feminist health ideas—the desirability and availability of women healthcare providers, the benefits of warming speculums prior to use, et very much cetera—were taken up on a national basis, including in the American south. In a context of national transformation, we are, as historians, obligated to look at the question of just how national the transformation was.

To understand the widespread presence of feminist women's health in the American south is to better understand the depth and breadth of the acceptance of feminist thinking around health. It is to appreciate that southern women shared the same desires as their coastal and northern sisters (to say nothing of the Midwesterners, westerners, and southwesterners!) to learn about their own bodies, to be respected and taken seriously in healthcare contexts, and to achieve autonomy over medical decision-making. But at the same time, it is to comprehend that existing within a southern context could have particular and meaningful ramifications for whether and how women were able to manifest feminist alternatives for their own health care, particularly relative to race, class, and southern sub-region. The title of this project, *Southern Women, Feminist Health*, is in short not an oxymoron, but rather an integral aspect of understanding both the extensive history and the

discipline-altering, industry-changing influence of feminism on healthcare and medicine in the contemporary United States.

Appendix:
Some Southern Women's Health Organizations and Abortion Providers, 1970-1995

This list represents an inevitably incomplete collection of southern women's health organizations including abortion providers that existed between 1970 and 1995 as they appeared in a variety of archival documents consulted for this project.

Organization names are given as listed in period documents. Where known, addresses are given. Telephone numbers are given where they were listed in the archives consulted for this project. It should be emphasized that the addresses, telephone numbers, et cetera may or may not be current and that indeed any given organization may or may not still be in operation.

Note that not all of these healthcare organizations are or were feminist in their orientation or makeup. All were, however, listed in documents found in collections relating to or the property of feminist organizations.

This list should not be used as a reference source for finding health care providers.

ALABAMA

Summit Medical Center
1032 18th St. South
Birmingham AL
35205

Women's Community Health Center of Huntsville Inc.
131 Longwood Drive
Huntsville AL

Sex Health Education / SHE Center
328 South Sage Ave. Suite 100
Mobile AL
36606

Martin Luther King Clinic
Rt. 1, Box 125A
Browns AL
36724

Montgomery Women's Medical Clinic
3866 S. Court Street
Montgomery AL
834-5195

Reproductive Health Services

1203 East South Blvd
Montgomery AL
281-7240

Beacon Women's Center (A Summit Center)
1011 Monticello Court
Montgomery AL
277-6212

Birmingham Women's Medical Clinic
1001 17th South
Birmingham AL
933-1847

Planned Parenthood of Alabama
1211 27th Pl. South
Birmingham AL
322-2121

New Woman Health Care
1513 4th Ave. South
Birmingham AL
322-2273

ARKANSAS

Fayetteville Women's Health Collective
210 Locust St.
Fayetteville AR
72701
501) 443-2000

Mari Spehar Health Education Project
Deep End Box 545
902 West Maple
Fayetteville AR
72701

Women's Community Health Center / SHE Center
1221 Westpark Drive
Little Rock AR
72204
(501) 666-5457

FLORIDA

Alternative Birth Center

1232 Laura Street
Jacksonville FL
32206

Birthplace
635 NE First Street
Gainesville FL
32601

Gainesville Women's Health Center
805 SW 4th Avenue
Gainesville FL
32601

Health Education Learning Program
Box 514
Cocoa Beach FL
32931

Feminist Women's Health Center
1017 Thomasville Road
Tallahassee FL
32303

Women's Center Health Group
Box 1350
Tampa FL
33601

Options, Inc.
1825 Hendricks Ave.
Jacksonville FL
32207

Tampa Women's Health Center
PO Box 7350
Tampa FL
33601

Jacksonville Women's Health Organization
2203 Art Museum Drive Suite 210
Jacksonville FL
32207

Central Florida Women's Health Organization, Inc.
609 E. Colonial Drive
Orlando FL
32803

Women In Distress, Inc.
122 NE 24th St.
Miami FL
33137

Women's Medical Center
7821 Coral Way, Suite 131
Miami FL
33155

Sex Health Education Center
12550 Biscayne Blvd.
North Miami FL
33181

Women's Center for Reproductive Health
PO Box 2091
800 Lomax Street Room 108
Jacksonville FL
32203

Sarasota Women's Health Center
5025 N. Tamiami Trail
Sarasota FL
35580

GEORGIA

Feminist Women's Health Center
1924 Cliff Valley Way NE
Atlanta GA
30329

Feminist Women's Health Center
Athens GA

Chrysalis Women's Center / Partners in Health
Atlanta GA

Columbus Women's Health Organization
1226 Third Avenue
Columbus GA
31901

Atlanta Center for Reproductive Health
1285 Peachtree St.

Atlanta GA
30309

Childbirth Alternatives Network
Winterville GA

National Black Women's Health Imperative
Atlanta GA

Atlanta Surgi-Center
1113 Spring Street NW
Atlanta GA
30309
404-892-8608

Atlanta Northside Family Planning
5675 Peachtree-Dunwoody Street
Suite 410, Building B
Atlanta GA
30342
404-256-2250

Atlanta Women's Medical Center
3316 Piedmont Rd. NE.
Atlanta GA
30305
404-262-3920

Planned Parenthood of East Central GA
1289 Broad Street
Augusta GA
30901
404-724-5557

Multi-Care
5675 Peachtree-Dunwoody Rd.
Atlanta GA
30342
404-257-1009

LOUISIANA

New Orleans Women's Health Collective (NOW)
1117 Decatur
New Orleans LA

70116

Delta Women's Clinic
1406 St. Charles Ave.
New Orleans LA
70130

Delta Women's Clinic
4826 Jamestown Ave.
Baton Rouge LA
70808

Acadian Women's Clinic
1820 North Acadian Thruway West
Baton Rouge LA
70802

MISSISSIPPI

Women's Health Collective
5428 N. Venetian Way
Jackson MS
39211

Lowell Women's Center
Route 1
Box 975
Ruleville MS
38971

Family Health Services
PO Box 5113
Jackson MS
39216

Lesbian Front
PO Box 8342
Jackson MS
39204

NORTH CAROLINA

Female Liberation / Women's Health and Pregnancy Counseling Service
Box 954
Chapel Hill NC

Women's Health Counseling Service, Inc., Switchboard

112 N. Graham Street
Chapel Hill NC
27514

Mountain People's Clinic
Eagle Street
Heyesville NC
28904

The Fleming Center, Inc.
3613 Hayworth Drive
Raleigh NC
27609

SOUTH CAROLINA

Women's Advocacy Center
PO Box 2054
Charleston SC
15206

Abortion Interest Movement
25 Country Club Drive
Greenville SC
29605

Columbia Women's Center
1900 Haywood Street
Columbia SC
29205

Southern Women's Services
1614 Two Notch Road
Columbia SC
29204
254-4368

Ladies Clinic of South Carolina, Inc.
1411 Barnwell St
Columbia SC
29201
803-254-7553

Ladies Clinic of South Carolina, Inc.
5814 Rivers Ave
Charleston SC
29406

803-554-0323

Ladies Clinic of South Carolina, Inc.
420 Dave Lyle Blvd.
Rock Hill SC
29730
803-329-2004

Ladies Clinic of South Carolina, Inc.
#2 Pendleton Medical Court
Greenville SC
29061
803-223-2846

TENNESSEE

Health Group -- YWCA
200 Monroe Avenue
Memphis TN
38103

Health Group, Nashville Women's Center
1112 19th Avenue South
Nashville TN
37212

Memphis Center for Reproductive Health
1462 Poplar Avenue
Memphis TN
38104

Memphis Center for Reproductive Health
202 Union Avenue Suite 401
Memphis TN
38103

Knoxville Center for Reproductive Health
1547 W. Clinch
Knoxville TN
37916

Women's Clinic of Murfreesboro
Terry J. White, MD
507 Highland Terrace
Murfreesboro TN
37130

TEXAS

Austin Women's Health Center
1902 Interregional Highway
Austin TX
78741

Houston Women's Health Collective
1201 Welch #2
Houston TX
77006

Rosie Jiminez Fund
711 San Antonio St.
Austin TX
78701

Vikki & Jane
Austin TX
454-1795

Women's Center of Dallas Health Group
2001 McKinney #300
Dallas TX
75201

Fairmount Center
2921 Fairmount
Dallas TX
75201

Women's Center of Dallas
3107 Routh St.
Dallas TX
75201

Routh St. Women's Clinic
4228 N. Central Expressway #201
Dallas TX
75206

Birth Control and Problem Pregnancy Counseling and Referral
YMCA University of Texas
2330 Guadalupe
Austin TX 75201

Cullen Women's Center, Inc.

7443 Cullen Blvd.
Houston TX
77051

Southwest Women's Center
6565 DeMoss
Houston TX
771-0611

Dallas Women's Center
8350 N. Central Expressway / M-2055 Campbell Center
Dallas TX
75206

Pregnancy Control, Inc.
1201 W. Presidio
Fort Worth TX
76102

Reproductive Services, Inc.
8606 Village Drive
San Antonio TX
78217

Houston Area Women's Center
Women's Referral Education Services (WIRES)
1010 Waugh Drive
Houston TX
77019

Houston Women's Health Center
1920 Richmond #2
Houston TX
77006

VIRGINIA

Women's Health Collective
Box 3760 University Station
Charlottesville VA
22903

The Women's Center of Northern Virginia
133 Park Street NE
Vienna VA
22180

BirthCare
1501 King Street
Alexandria VA
22314

Alliance for Perinatal Research and Services, Inc.
321 S. Pitt St.
Alexandria VA

Richmond Medical Center for Women
118 North Boulevard
Richmond VA
23220

Women's Health Center
1114 E. High St.
Charlottesville VA
22901

Northern Virginia Women's Medical Center
3918 Prosperity Avenue
Fairfax VA
22031

WEST VIRGINIA

Kanawha Valley Women's Health Group
1114 Quarrier St.
Charleston WV
25301

Raleigh City Women's Health Collective
Cool Ridge WV
25825

Women's Health Center of West Virginia
3418 Staunton Avenue SE
Charleston WV
25304

Archives and Special Collections

Sallie Bingham Center for Women's History and Culture, David M. Rubenstein Book and Manuscript Library, Duke University
Atlanta Feminist Women's Health Center collection
Atlanta Lesbian Feminist Alliance collection

The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute for Advanced Study, Harvard University
Boston Women's Health Book Collective papers
Women's Community Health Center papers

Sophia Smith Collection, Smith College
Byllye Avery papers
National Black Women's Health Project papers
National Women's Health Network papers
Loretta Ross Papers

Spelman College Archives, Spelman College
First National Conference on Black Women's Health Issues papers
Spelman *Messenger*

Woman's Collection, Texas Women's University
Choice Foundation papers

Women's Library Collection, University of Arkansas Libraries Special Collections
Mari Spehar Health Education Project papers
Women's Library papers

Archives and Manuscript Collections, George A. Smathers Libraries, University of Florida
Popular Culture Collection
Radical Women in Gainesville Digital Collection
Records of the Florida National Organization for Women

Private Collections

Private Collection of the Atlanta Feminist Women's Health Center
Private Collection of Donna Burnell
Private Collection of Barbara Esrig
Private Collection of the Memphis Center for Reproductive Health

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