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By

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Abstract

This dissertation examines the National Black Women's Health Project (NBWHP), the first organization devoted solely to the health of black women. The Project was a unique organization because it was one of the first which argued black women, because of the multiple jeopardies of racism, classism, and sexism, must fight the forces negatively impacting their emotional, physical, and spiritual health. These forces, Project members argued, included their white counterparts in groups such as the National Women's Health Network, the Project's mother organization. Troubled by the lack of information on black women's health issues, NBWHP founder Byllye Avery sought to remedy the situation by hosting a national conference on black women’s health issues at Spelman College in 1983. It was at this conference that black women demanded the formation of an independent health organization, not just a program of a predominantly white health group, a group which too often glossed over the health concerns of women of color.

NBWHP leaders insisted they needed their own organization which addressed their health issues. Many of the founders had been involved on some level with white women's health organizations, and most continued to have friendly relationships with white activists. However, none of the founders felt that the larger Women's Health Movement did enough to improve the health status of black women The movement did not adequately integrate women of color's health care issues into their programs. Their insistence that there was a universal female experience erased the unique health concerns of women of color. Black women, through the guidance of the NBWHP, began writing their own agenda and developing their own programs.

In crafting a new agenda, the Project created a space where women of color could
articulate their own needs and ideas. This space was necessary for black women to analyze their experiences and develop responsive programs. As NBWHP members noted again and again, black women's lives were quite different from white women. The movement's emphasis on self-exam, for example, was not as important to black women who fought for their lives on a daily basis. Their priorities simply did not match. White health feminists wanted an inclusive movement, but it did not appear that interracial organization in women's health groups helped achieve this goal.

Project members were not interested in separation, however, which suggested a clean break from other organizations. Rather, the Project sought independence from white organizations. Independence meant that Project members could write their own agenda, but it left room for inter-organizational alliances. For Project members and other women of color, inclusion did not mean that they had to join white women's groups. On the contrary, inclusion meant that all women, regardless of their race, would be able to organize themselves while building alliances and coalitions with each other. The explosion of health activism amongst women of color after the Project's founding shows that the time was ripe for women of color to organize themselves around their group's health issues, making the movement more inclusive and responsive in the process.
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<tr>
<td>AHMA</td>
<td>American Holistic Medicine Association</td>
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<tr>
<td>BWA</td>
<td>Black Women's Alliance</td>
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<td>BWOA</td>
<td>Black Women Organized for Action</td>
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<td>BWHBC</td>
<td>Boston Women's Health Book Collective</td>
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<td>CBWW</td>
<td>Center for Black Women's Wellness</td>
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<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<td>FFWHC</td>
<td>Federation of Feminist Women's Health Centers</td>
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<td>NABF</td>
<td>National Alliance of Black Feminists</td>
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<td>NAWHO</td>
<td>National Asian Women's Health Organization</td>
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<td>NBFO</td>
<td>National Black Feminist Organization</td>
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<td>NBWHP</td>
<td>National Black Women's Health Project</td>
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<td>NLHO</td>
<td>National Latina Health Organization</td>
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<td>NOW</td>
<td>National Organization for Women</td>
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<td>NWHN</td>
<td>National Women's Health Network</td>
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<td>NAWHERC</td>
<td>Native American Women's Health Education Resource Center</td>
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<tr>
<td>PPEP</td>
<td>Public Policy and Education Program</td>
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<tr>
<td>RC</td>
<td>Re-Evaluation Counseling</td>
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<tr>
<td>R2N2</td>
<td>Reproductive Rights National Network</td>
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<tr>
<td>SDS</td>
<td>Students for a Democratic Society</td>
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<tr>
<td>SNCC</td>
<td>Student Non-Violent Coordinating Committee</td>
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<tr>
<td>TWWA</td>
<td>Third World Women's Alliance</td>
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Introduction

On June 24, 1983, approximately two thousand women gathered in Sisters Chapel on Spelman College's campus in Atlanta to help kickoff the first National Conference on Black Women's Health Issues. For many participants, the conference was the first time they had gathered with so many other women to discuss important health issues. “I had never seen such a large group of black women together working on women's issues before,” activist and conference participant Loretta Ross remembered.1 The women, exhilarated and inspired, streamed into the chapel in order to hear June Jackson Christmas's keynote address. Christmas, a professor and director of the Behavioral Science Program at The Sophie Davis School of Biomedical Education, opened the gathering as women crowded into the chapel, many standing in the aisles and around the walls to make room for more women. “We gather together for the health of black people,” Christmas declared “that we may do more than survive, that we may be able to fulfill our potential and be healthy, in body and mind, in family and community.” She continued, “[i]f we understand the problem- the political and economic forces which make and keep us 'sick and tired,' poor and oppressed, the interrelated forces of racism and sexism, then we must each choose to be part of the solution.”2 Inspired by Christmas' address and the rest of the conference activities, many women in the audience agreed to be part of the solution, dedicating themselves to improving their health and well-being.

This conference at Spelman College, sponsored by the National Women's Health Network (NWHN), was the first of its kind which specifically addressed the health concerns of women of

2 National Black Women's Health Project, The First National Conference on Black Women's Health Issues, Spelman College, Atlanta, Georgia: I'm Sick and Tired of Being Sick and Tired (Atlanta, GA: No Publisher Listed, 1983), 11.
color. Although women's health organizations, including the NWHN, had been hard at work for a
decade improving health care for women, no organization prioritized the unique health needs of
women of color. Byllye Avery, a middle-aged black woman from Florida, had worked for over a
decade within these predominantly white groups, growing frustrated by the lack of attention paid
to black women. Due to her close relationship with the NWHN, Avery convinced the
organization to sponsor a Black Women's Health Project and to support a conference on Black
Women's Health Issues. It was at this conference that black activists, including Avery, decided
that a NWHN project was not sufficient in addressing black women's health needs. These women
sought independence from the NWHN in 1984, forming the National Black Women's Health
Project (NBWHP) with Avery operating as the organization's director.

As an organization, the Project emerged in the midst of a number of movements which
had already been underway for over a decade. In particular, the Project was tied to civil rights,
feminism, and the movement for more democratic and accessible health care. The 1960s had
seen an explosion of health activism geared toward expanding health care access to the poor and
minorities. Neighborhood health centers and free health clinics, through the support of President
Lyndon Johnson's Great Society programs, began popping up through the country, providing
health services to individuals who had been underserved by traditional health care providers. In
particular, free clinics provided services that were “less expensive, less dominated by
professions, less hierarchical, and more open to advocacy and social change.”

The move toward a more democratic and accessible health care system led to the establishment of the Health
Policy Advisory Center (Health/PAC), a kind of clearinghouse which provided information,

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education, and technical assistance to groups interested in health activism. Additionally, Congress expanded access to health care to children, the poor, and the elderly through the Medicare and Medicaid programs, both passed in 1965. Expanding health care access to the poor, and making health care more democratic, were major goals of these activists.

Although poverty was a major impediment to health care, other activists noted that racism was another negative health barrier. Given that many racial minorities were impoverished, these activists argued, making health care more democratic and accessible would also necessitate a battle against racial discrimination. The fight against racial and economic oppression waged by civil rights activists throughout the 1950s and '60s was extended to the problems African Americans faced in seeking health care. In 1966, Martin Luther King Jr. addressed the Medical Committee for Human Rights (MCHR), an organization dedicated to the health needs of civil rights activists, arguing that “of all forms of inequality, injustice in healthcare is the most shocking and inhumane.”

Groups such as the Black Panther Party and the MCHR took seriously the problems of racism in health care and fought to ensure black Americans received adequate medical care. The MCHR worked throughout the 1960s and early 1970s to desegregate medical facilities and ensure black physicians were allowed into professional organizations. By 1970, the Black Panther's leadership mandated that all current and future chapters of the organization

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would have to open health clinics to serve the needs of African Americans. Health care discrimination was yet another sign of racial oppression, and activists sought to find ways to address inequalities in health care.

As civil rights activists worked to address racism in the health care field, feminists fought against sexism in the medical community, including within the neighborhood and free clinics established by other activists. Starting in 1969 with a group of women hosting a workshop on “women and their bodies,” the women's health movement grew quickly. That same year, Barbara Seaman published *The Doctors' Case Against the Pill*, an exposé on the dangers of hormonal birth control leading to a series of Senate hearings in 1970 on the safety of hormonal contraceptives. By 1971, activists Carol Downer and Lorraine Rothman were traveling the country, showing women how to view their own cervixes and supporting women in their founding of feminist alternative health clinics. In 1973, the Boston Women's Health Book Collective published the women's health text *Our Bodies, Ourselves.* And, in 1975, Seaman, Belita Cowan, Phyllis Chesler, Mary Howell, and Alice Wolfson founded the National Women's Health Network, a “watchdog of federal health policy; an information clearinghouse that worked to assist its members to be informed health care consumers.”

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dismantle the system which they believed used their bodies to oppress them. Taking control over one's body and health would be central to the process of empowerment, women's health activists insisted.

Women's health activists, in their attempts to empower women through knowledge of their bodies, made some critical assumptions about the universality of women's experiences. As historian Wendy Kline notes in her analysis of the women's health movement, health feminists saw health as an issue that would bridge barriers such as class, race, and sexuality, bringing together disparate groups of women. Rooting empowerment in the body led many health feminists to articulate a vision of a universal sisterhood partially based on female biology. Race, class, and sexual orientation may affect a woman's medical experiences, these activists argued, but all women were all similarly oppressed under America's biomedical health system.

These calls for a universal sisterhood were not an invention of health activists, however. The notion that sexual oppression was the most basic form of discrimination and that similarities in women's experiences cut across racial and class lines seemed naïve, if not insulting, to many women of color who were in the midst of struggles for racial liberation. Women's groups attempted to reach out to women of color, whom they believed were their natural allies, in their attempts to build an inclusive women's movement. According to Winifred Breines, white feminists tried to reach black women, but their attempts were often rebuked because some black women “were angry at white women and wary of them and the white women's liberation

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10 Morgen, *Into Our Own Hands*, 29-31. Cowan met Seaman while she was working on her own articles on diethylnitritol (DES), a drug given to women as a morning after contraceptive as well as to women suffering from morning sickness. Chesler was a psychologist who was interested in how psychiatry and psychology affected women. Howell was a physician and faculty member of Harvard Medical School.

movement.” Perhaps more importantly, however, many black women feared that involvement in the women's movement might “divert gains from the civil rights movement to white women and usurp black women's activist energies.” After all, as Kimberly Springer points out, there was a great deal of anxiety in black communities over black women as activist resources. If black women split their time between the two movements, many activists feared, would the movement for racial equality suffer?

Despite these concerns, many black women approved of the women's movement. Black women were not blind to gender politics. On the contrary, they articulated a sophisticated analysis of gender, racial, and class politics. Black women worked in the cracks of two movements, as Springer argues, facing a serious dilemma. As Kay Lindsey noted in Toni Cade's 1970 work *The Black Woman: An Anthology*, black women were caught in the middle. “The black movement is primarily concerned with the liberation of blacks as a class and does not promote women's liberation,” Lindsey wrote. The feminist movement, she argued, concerned itself with women's liberation, but was a movement dominated by white women. Thus, Lindsey argued, “the black woman finds herself on the outside of both political entities, in spite of the fact that she is the object of both forms of oppression.” In essence, women of color were being

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13 Kimberly Springer, *Living for the Revolution: Black Feminist Organizations, 1968-1980* (Durham, NC: Duke University Press, 2005), 31. Fears about black women's alliances and concerns over black women as activist resources were not unique to the 1960s and 1970s. As Deborah Gray White argues, at the turn of the 20th century, black women “found themselves caught in the middle of race and gender conflicts.” Black activists struggled against racial discrimination in all walks of life just as women were fighting for their civil right to vote. As activists throughout the 20th century, “black women were confronted with race, gender, and class issues that were sometimes in conflict, and were asked to pick a side.” Despite these demands, black women took “race, along with gender and class” into consideration as they fought for racial AND gender equality. Deborah Gray White, *Too Heavy A Load: Black Women in Defense of Themselves, 1894-1994* (New York: W.W. Norton & Company, 1999), 17.
forced to choose: would they devote their energies to liberating the race, or would they work to eliminate sexism? Many black women would not, and could not, make that choice. “I refuse to choose,” black feminist activist Dorothy King argued. “I refuse to choose between being black and being a woman . . . I am both equally, and I'm proud to be both.”

This tension between having to choose between two movements, and two identities, created an alternative space for political action. According to scholar Kimberly Springer, black feminists articulated a new kind of politics in the space between these movements. “Interstitial politics,” or “politics in the cracks,” required black feminists to develop “a collective identity and basis for organizing that reflected the intersecting characteristics that make up black womanhood.” It was in these cracks that black feminists began crafting a unique analysis of oppression based on how racism, sexism, class issues, and heterosexism all worked to negatively affect black women's lives.

The idea that oppressions were interlocking or intersecting was a theory that black feminists articulated as they struggled to balance their concerns with both racial and gender oppression. In 1970, Frances Beale, a member of the Student Non-Violent Coordinating Committee (SNCC) and the founder of the Black Women's Alliance (BWA), a feminist group associated with SNCC, penned “Double Jeopardy: To Be Black and Female.” In the article, Beale argued that black women faced a double burden as black women; they had to grapple with both gender and racial oppression. That same year, black feminist Linda La Rue rejected the

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notion that black women could “separate their femaleness from their blackness.”18 And, in their famous 1977 “A Black Feminist Statement,” the Combahee River Collective, a former chapter of the National Black Feminist Organization (NBFO) and one of the first black lesbian organizations, described the interlocking nature of oppressions. As black women, Collective members found it “difficult to separate race from class from sex oppression because in our lives they are most often experienced simultaneously.”19 Quite simply, black feminists made it clear that white feminists' cries for a universal sisterhood ignored the complicated ways in which multiple oppressions affected black women's lives.

For many black women, then, organizing independently became crucial. After all, no other group really understood the unique ways oppression affected black women. As the Combahee River Collective argued, “the most profound and potentially the most radical politics come directly out of our own identity, as opposed to work to end somebody's else's oppression.”20 This ethos of organizing one's own, also known as identity politics, became critical to feminists of all stripes, not just women of color. As Benita Roth argues, white feminists had adopted this ethos when they split from New Left groups in the late 1960s, largely inspired by groups such as SNCC and Students for a Democratic Society (SDS). The argument went that “the most authentic and, therefore, most radical forms of activism involved fighting one's own oppression.”21 Only those who understood their oppression could hope to liberate themselves, activists from a number of movements insisted. This idea was particularly attractive to white feminists who articulated their own desire to organize women around sexual oppression.

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20 Ibid., 234.
21 Roth, Separate Roads, 202.
Men in groups such as SNCC and SDS could not liberate women. They would have to do it themselves.

Organizing one's own for white feminists, however, meant that they would try and organize all women, despite their racial or class differences. As noted before, they forwarded a vision of universal sisterhood which assumed that difference was relatively unimportant. Feminists of color, on the other hand, did not share this vision. Racial and class privilege strained relationships between white and black feminists just as tensions concerning gender roles caused friction between black men and women in activist groups. Because black women fell into the cracks, independent organization was one of the few solutions open to black feminists. No other group or movement explored the interlocking nature of oppressions, leaving black women (and other women of color) to organize themselves. As Breines notes, organizing “on the basis of one's own identity was the only strategy that made sense” to many black women.22 By the mid-1970s, black feminist had founded numerous groups, including the Third World Women's Alliance (TWWA), the National Black Feminist Organization (NBFO), the National Alliance of Black Feminists (NABF), the Combahee River Collective, and Black Women Organized for Action (BWOA).23 For white feminists, many of whom truly believed in the importance of an inclusive movement, the perceived separation between themselves and black feminists was difficult. In remembering the tensions between black and white feminists, Winifred Brienes describes how she grieved “for lost interracial connections among women.”24 In the eyes of many white feminists, who had tried to grapple with their own racism and racial privilege, the split between white and black meant the death of a truly inclusive movement.

22 Breines, Trouble Between Us, 147.
24 Breines, Trouble Between Us, 14.
This work explores the ways in which the NBWHP navigated the difficult terrain of organizing as black feminists. Although the organization emerged just as a number of black feminist organizations were falling apart, roughly 1980, the Project owed a great deal to the activists involved in the larger women's movement, both white and black. Like many black activists before her, Avery became increasingly frustrated with the lack of attention paid to black women's issues by white feminists. Avery matured into an activist alongside her white colleagues as she fought sexism within health care, first as part of a Feminist Women's Health Center, then as a founder of an alternative birthing center, and finally as a board member of the NWHN. Although the white women she worked with were committed to improving health care for women, they largely failed to explore the ways in which race affected black women's health care experiences. Many of the white activists Avery struggled alongside were not blind to racial differences, and building an inclusive movement which was sensitive to the needs of women of color was an important goal of these activists. However, they largely followed the path that Wendy Kline describes in her analysis of the women's health movement. White health feminists truly believed that they could cross the “socially created barriers of race, color, income, and class” in order to “feel a sense of identity with all women in the experience of being female.” In essence, these activists supported the largely feminist notion of universal sisterhood, a sisterhood in which black women were not particularly invested.

Like many of the black feminists who came before her, Avery often felt frustrated by white women in the movement. She could not overlook the fact that she was often one of only a few women of color involved in organizations like the NWHN, and she could not ignore the lack of attention these groups paid to the health concerns of women of color. It is important to note,

25 Quoted in Kline, Bodies of Knowledge, 3.
however, that these white activists were supportive of Avery's attempts to shift the movement's agenda toward examining black women's health issues. In 1981, when Avery approached the NWHN with her plan for a Black Women's Health Project, the board backed Avery at every turn. The NWHN's moral and financial support made the first conference on black women's health issues in 1983 possible.

What the conference revealed, however, was that black women needed more than the support of a predominantly white organization; they needed their independence. Echoing the Combahee River Collective, participants at the 1983 conference argued that no other group would fight for their liberation; it was up to them. Declaring their independence from the NWHN in 1983, the Project became an official non-profit in 1984, solidifying their position as the first organization devoted solely to women of color. It would not be the last, however. In 1986, a group of Latina women founded the National Latina Health Organization (NLHO). The Native American Women's Health Education Resource Center (NAWHERC) opened its doors in 1986, and Asian activists founded the National Asian Women's Health Organization (NAWHO) in 1993. These groups and their founders all pointed to Avery and the NBWHP as inspirations and models for organizing themselves.

Clearly, women of color felt they needed their own organizations which would address their unique health concerns. Almost all the founders of these groups had been involved on some level with white women's health organizations, and most continued to have friendly relationships with white activists. However, none of the founders felt that the larger movement was doing enough to improve the health status of women of color. The movement, which stressed the importance of women's experiences in guiding the movement's agenda, did not adequately
integrate women of color's health care issues into their programs. Their insistence that there was a universal female experience erased the unique health concerns of women of color. Black women, through the guidance of Avery, began writing their own agenda and developing their own programs which would ultimately inspire other women of color to organize.

In crafting a new agenda, Avery and the Project created a space where women of color could articulate their own needs and ideas. This space would be necessary for black women to analyze their experiences and develop programs which would be more responsive to women of color. As participants in the first conference noted again and again, black women's lives were quite different from white women. The women's health movement's emphasis on self-exam, for example, was not as important to black women who were fighting for their lives on a daily basis. Their priorities simply did not match. White health feminists wanted an inclusive movement, but it did not appear that interracial organization in women's health groups were achieving this goal.

Building an inclusive movement would not be an easy task. In discussing race in the larger women's movement, Winifred Breines suggests that “separation was a vital ingredient in feminist political work.” Feminists, both white and black, “had to separate to learn who they were in the race, class, and gender terms constructed by American society.”26 Thus, in Breines's analysis, black feminists' desire to form their organizations was evidence of their need to separate from white women. In this view, the Project had to separate from the NWHN in order to realize who they were, a process which Breines describes as “disturbing,” especially to the white feminists who were working hard to overcome racial difference.27

I would argue, however, that Project members were not interested in separation, which

26 Breines, Trouble Between Us, 16-17.
27 Ibid., 16.
suggested a clean break from other organizations, especially from predominantly white groups. Instead, the Project sought independence from white organizations. Independence meant that Project members could write their own agenda, but it left room for inter-organizational alliances. “This independence [from the NWHN] was and is not intended to be seen as a move to terminate alliances with any organization or individuals,” Project leaders insisted. “This quest for self-definition does not preclude our collectivity with other organizations.”28 Far from disturbing, the shift to independence was positive, giving women of color the space to articulate their needs, develop their own programs, and evolve as activists. Empowerment, a requisite for activism, would be difficult for women of color to achieve in organizations where white women dominated the leadership and crafted the agendas. For Project members and other women of color, inclusion did not mean that they had to join white women's groups. On the contrary, inclusion meant that all women, regardless of their race, would be able to organize themselves while building alliances and coalitions with each other. The explosion of health activism amongst women of color after the Project's founding shows that the time was ripe for women of color to organize themselves around their group's health issues, making the movement more inclusive and responsive in the process.

Four chapters explore how Avery and others within the NBWHP helped develop a space for women of color to advocate for the own health needs. Chapter one charts Byllye Avery's growth as an activist. The Project was Avery's child, and her life experiences were crucial to the formation of the Project. Involved early in the women's health movement, Avery helped found a Feminist Women's Health Center, an alternative birthing center, and joined the board of the NWHN. She gained a number of skills as she worked alongside white women, but she could not

28 Quoted in Morgen, Into Our Own Hands, 46.
overlook the fact that she was often one of the only women of color working in these organizations. Recognizing the ways in which race affected her experiences as both an activist and health care consumer, Avery began conceptualizing a project which would provide black women the space to explore the ways in which racial, gender, and class oppressions intersected in black women's lives, affecting their mental, physical, and spiritual health. Her experiences had shown her that the goals of the larger women's health movement did not always take into account the needs of women of color, so she sought to rectify this by hosting a conference on black women's health issues. This conference, held on Spelman College's campus in Atlanta in 1983, would birth the NBWHP, the first organization devoted solely to the health concerns of women of color.

Chapter two discusses the development of the Project's self-help process, a program which aimed to aid black women in overcoming internalized oppression, a necessary step toward empowerment. The larger women's health movement worked to provide women with knowledge of their bodies, a knowledge they insisted empowered women. The Project, however, noted that knowledge was only part of the equation. The psychological scars of racism and sexism had left black women with a deeply negative self-image. Facing internalized oppression would have to be the first step on the path toward empowerment. Re-defining what it meant to be a black woman would allow black women to reject dominant notions of black womanhood in favor of a supportive and empowered identity. In crafting this program, the NBWHP turned to re-evaluation counseling (RC), a relatively new counseling theory, as well as to the self-help concept supported by white health feminists. Once empowered by the self-help process, black women would be able to address health inequities. One of the Project's most important legacies, self-help became a
model for other women of color as they began building their own organizations.

Self-help, however, would not necessarily improve systemic health inequities. Chapter three discusses the Project's plan to address black women's poor health status. Self-help would empower black women, but this was only part of the equation. Avery's own experiences with health care had shown her that physical health was inextricably linked to one's mental, spiritual, social, and economic wellness. Biomedicine, which saw health as purely biological, did not take into account the complicated relationship between health and socioeconomic factors. Given black women's poor health status, it was clear to Project leaders that they would have to re-conceptualize health for their members. Turning to critics of biomedicine, including activists within the women's health and holistic health movements, the Project crafted a new vision of health. Adapting the notion of holism and the critiques of reductionism and medical authority, the Project envisioned health wholistically. Black women needed a wholistic vision of health, one which took into account all aspects of a woman's life and health (physical, mental, and spiritual). Only when health was approached wholistically, the NBWHP argued, would there be real changes in the lives of black women and their communities.

The final chapter explores the Project's attempts to build coalitions and alliances with other female health activists. Although the Project insisted independence was necessary for an inclusive movement, it continued to develop its relationships with other women's organizations. Organizing one's own did not preclude alliances. On the contrary, inclusion would require women to work together, albeit in independent organizations. To this end, the Project crafted a program, "Sisters and Allies," which attempted to teach white women how to use self-help in order to analyze racism and racial privilege. Avery and the Project remained committed to
interacial alliances, but white women had to confront their guilt surrounding racism, otherwise these relationships would fall apart.

Perhaps more importantly, however, the chapter also explores the interactions between Project members and other activists of color. Viewing the Project as a pioneer in the movement, Project leaders, especially Avery, encouraged other women of color to organize themselves. Black women could not speak to the unique health concerns of Latina, Native American, or Asian American women. Project leaders felt a sense of solidarity with other women of color based on their racial, gender, and class oppression, but acknowledged that differences between the groups meant that independent organizations would be necessary. Serving as inspiration to women of color both home and abroad, the NBWHP became the vanguard of the movement, forcing health activists to confront difference while also bridging these divides. The Project helped foster a community for activists of color, a community which would support women of color as they formed their own organizations.

At all points in the development of the Project, Avery played a central role. As discussed in the conclusion, Avery was the heart of the Project. She was responsible for the organization's independence, and her own experiences informed the development of both the self-help process and the Project's wholistic vision of health. Although other NBWHP were important to the Project, Avery was the group's foundation. By 1989, interpersonal tensions and Avery's exhaustion had begun to turn the Project into a new organization. Once Avery stepped down as Executive Director in 1990, the Project began evolving into a new organization, a process which was complete when it became the Black Women's Health Imperative in 2002. As noted in the conclusion, once the Project abandoned its self-help program and shifted its focus to federal
policy, the group was all but unrecognizable to its founder. This evolution, however, does not
detract from the Project's importance. The NBWHP forced the women's health movement to
become more inclusive, inspiring thousands of women in the process. Although it is impossible
to measure the Project's success in empowering women of color, the rapid development of other
groups modeled off the Project suggests that the NBWHP had done a great deal in pushing the
movement toward inclusion and empowering women of color to become activists and advocates
for their own health needs.
Chapter 1

“The Conspiracy of Silence is Killing Us:” Byllye Avery and the Founding of the National Black Women's Health Project

“The [National] Black Women's Health Project was just the most important thing in the world that could ever happen to me,” Byllye Avery, the founder of the National Black Women's Health Project (NBWHP), recalled during a 2005 interview. “It was my everything. I loved every minute of it . . . it was life changing for all of us who were doing the work. We were changing as we were working. And I remember for several years, for about four or five years, almost every Saturday there was something going on around the country around black women's health. People were making changes. People were being aware. It was truly a wonderful, wonderful time.”

The first decade of the NBWHP was a magical time for Avery. As the Project's founder and first Executive Director, Avery was the foundation of the organization for the first nine years of its existence. From 1981, when Avery convinced the National Women's Health Network (NWHN) to sponsor her Black Women's Health Project, to 1990, when she stepped down as Executive Director, Avery was truly the backbone of the organization, giving it life and creating a space for black women to organize around their health issues.

Given Avery's importance at all points in the development of the NBWHP, it makes sense to start the story of the organization with Avery herself. After all, as the authors of Undivided Rights note, the “history of the NBWHP is a story of charismatic leadership.” For much of the Project's early history, Avery was the organization's guide, leader, and inspiration. Although there were other black female health activists working throughout the country in the 1970s and '80s, it

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was Avery who truly pulled women from all walks of life into the women's health movement. In part, she was able to do this by using her own life experiences to set a guiding program for the Project. As Avery herself notes, “many community-based organizations arise out of personal experiences” and it is these groups, born out of the experiences of founders and members, “that have their fingers on the pulse of the people.” For the NBWHP, one of these community-based organizations, Avery's life experiences became crucial to the formation and development of the guiding ideology of the organization.

In particular, Avery's political awakening was critical to the formation and development of the NBWHP. In many ways, Avery's entrance into activism was unique. As numerous scholars and historians have noted, many black female activists of the 1960s and 1970s viewed the battles to end racism as a primary concern, but they also crafted a sophisticated analysis of the interconnections between racial and sexual oppression. For many black feminists, neither black men nor white women truly understood the ways in which racism, sexism, and classism impacted black women's lives. Frustrated by sexism within civil rights groups, but wary of racism within the women's movements, black feminists generally either founded separate organizations and/or opted not to join white women's groups. Avery's path, however, differed in important ways.


Although aware of the movements for racial liberation, Avery found herself more attracted to feminism and its discussion of gender roles and women's lack of satisfaction with their lives. Inspired by Betty Friedan's feminist classic *The Feminine Mystique*, Avery began making connections with other women, most of whom were white, in order to analyze gender oppression. Life experiences, especially the death of her husband, pushed Avery toward the women's health movement. It was here, as she worked alongside white women, that Avery began to analyze how racial and gender oppression intersected, especially in regards to health care. Joining with the NWHN soon after its founding in 1975, Avery now had the power and resources to explore these connections in greater detail, connecting with other black women who were interested in similar issues.

As an activist, Avery's greatest legacy was the crafting of a space for black women to explore the ways in which racial, gender, and class oppressions intersected in black women's lives, affecting their mental, physical, and spiritual health. As Avery learned time and again, her experiences as a black woman differed from the white activists around her. Racism, poverty, and poor self-esteem all affected black women's access to adequate health care. Although she supported the agenda of predominantly white groups such as the NWHN, Avery understood that black women needed to organize themselves around their own health issues if there were to be any positive changes in their lives. Well-meaning white activists tried to make the movement more inclusive by including women of color in their organizations, but Avery's experiences showed her that joining existing groups would not necessarily make the movement more inclusive. Black women would have to articulate their own agenda and form their own organizations if their health concerns were going to be met by the movement.
Although this chapter focuses on Avery's development as an activist, it is important to note that I take seriously historian Charles Payne's warning to scholars of social movements not to focus too heavily on the heroes and heroines of social movements. As Payne argues, part of the legacy of activists, like Avery, who believed in the power of ordinary people “is a faith that ordinary people who learn to believe in themselves are capable of extraordinary acts.”

Avery herself was one of these ordinary persons who helped found an organization which would help meet the needs of black women. This chapter traces Avery's development as an activist to understand the birth of the NBWHP, since she was truly the organization's mother, but it is important to note that other activists, many of whom will be discussed in subsequent chapters, helped shape the Project into the organization they needed. Avery created the space for black women to learn how to organize and empower themselves, but these ordinary women were the ones who made the changes necessary to improve their health and well-being.

The Birth of an Activist

Byllye Yvonne Reddick Avery's life began like many young, black women in the pre-war rural south. Born in Waynesville, Georgia in 1937, Avery lived in the same home where her mother, her seven aunts and uncles, and fifteen of her cousins had all spent their formative years. Avery knew little about her father, except for his name, and the main male presence in her life was her step-father. When Avery was just a few months old, her mother married Quitman Davis Reddick and moved the family to DeLand, Florida where Avery spent the majority of her childhood with her mother, stepfather, brother, and adopted brother. Life in DeLand taught Avery a great deal about gender, racial, and health issues even though it would be much later in

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6 Avery interview, 1-2
her life until she was able to politicize these events and develop her activism around issues she learned as a child and young woman.

DeLand, Florida was a small, mostly rural town of around 5,000, and it was here that Avery began to develop an awareness of her own race and the issues black Americans faced throughout the South. The Reddick family lived two blocks from the main street in a section of town called Africa. For Avery, living in “Africa” was a cause for shame and embarrassment. “It wasn't that time when we had pride around Africa,” Avery recalled. “We were all upset because we thought it meant we were all wild and didn't know how to do anything.” School segregation in DeLand bolstered these feelings, making it obvious to Avery that white residents in DeLand viewed black and white children quite differently. Avery, her brothers, and other black students attended Euclid Elementary and Euclid High School, a racially segregated and run-down institution a mile outside of DeLand. Every day, according to Avery, she and her brothers walked through town in order to get to school and “the thing is, we walked right by DeLand High School, which was the white high school, every day,” a school which was obviously better funded making it even more obvious that blacks in DeLand were treated as second-class citizens. Segregation was merely a fact of life for Avery at this age, not a politicizing or radical experience. It would be years before Avery could articulate the ways in which shame and segregation negatively impact the health of black women.

While living in DeLand, Avery also learned a great deal about how violence and health

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7 Avery interview, 4.
8 Ibid., 4-5. Avery was 17 years old when the Supreme Court ruled school segregation unconstitutional in its 1954 decision Brown v. Board of Education. Although she graduated in 1955, a year after the decision, her high school did not integrate immediately. This was not uncommon. As Harvard Sitkoff notes, by 1960 only one-sixth of one percent of black students in the South attended integrated schools. By 1964, the situation only improved slightly with two percent of black students attending integrated schools. Harvard Sitkoff, The Struggle for Black Equality, 1954-1992 (New York: Hill and Wang, 1993), 36.
problems can wreak havoc on families. At fifteen, an unnamed man murdered Avery's stepfather during a violent altercation. Reddick owned a “gyp joint” (an illegal gambling and drinking establishment) in a small town outside of DeLand.9 In the back of the gyp joint, men gambled and on the evening of Reddick's death, a group, including Reddick, accused another man of cheating. The man “cut my father on the wrist and my father then got in the car and drove and shot this man's heart in two.” Although the circumstances of Reddick's death are a bit unclear, after he murdered the other man, a friend drove Reddick to the hospital where he died. As Avery notes, “he was a violent man, anyway, you know? He lived by it and he died by it.”10 Reddick's death had an immediate and dramatic effect on Avery's family, turning it into a single family household attempting to survive on one salary. The stress, and income hit, affected all members of the family. This early incident of violence would be in Avery's mind later in life when she began articulating the myriad of problems facing black families and communities. Violence in black communities became a critical black feminist issue, and the NBWHP would later view it as a crucial health issue for black women.

More obvious health issues also played an important role in Avery's early years. Avery's younger half-brother, Quitman Davis Reddick, died in 1991 from multiple sclerosis. Unfortunately, Reddick suffered from the disease for years before his death. Avery notes it was “a long time before it was ever diagnosed.”11 Although Avery did not go into great detail about her brother's death, her brief discussion of his illness, as well as her anger over the time it took for him to be diagnosed, makes it clear that his illness deeply affected her. Additionally Avery's Aunt Earline, who was a sharecropper in South Carolina, died at a young age. As Avery

9 Avery interview, 2.
10 Ibid., 2.
11 Ibid., 3.
remembers, in 1944 her family visited their relatives on their farm in South Carolina to meet Earline's new baby. A few months after this trip Earline died, although Avery does not describe the circumstances. Avery's mother went to the funeral and came home with Avery's cousin, who became her adopted brother. As Avery would later find out, her mother and her aunt had made an agreement to raise each other's children if it became necessary. Death at an early age once again upset the balance of Avery's family. The suffering of her brother and the deaths of her step-father and aunt undoubtedly affected Avery's notion of health and wellness and opened her eyes to the impact early deaths had on black families.

Early in her life, Avery learned how race, violence, and death affected her life and the community around her. In addition, Avery grappled with the responsibilities her family gave her based on the fact that she was female. Avery admits that being the eldest daughter might have put her into the position to be spoiled, but she shouldered a great deal of responsibility. Her mother expected that she would become a surrogate mother to the family while she was at work. “I grew up as a work child,” Avery remembers, “so that I was constantly working all the time. . . my mother would tell me on her way out, when I come back home from school . . . we're going to have fried chicken. And that meant I had to catch the chicken, I had to kill the chicken, I had to clean the chicken, and I had to cut the chicken up, and I had to cook the chicken and have it ready.” Avery and her brothers were also responsible for helping to raise hogs, chickens, geese, and ducks on their property in order to help the family survive living in a rural area. Avery quickly learned that her family assumed women were responsible for caring for the family, even if a woman worked outside the home like her mother, and that there was no question Avery

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12 Avery interview, 3-4.
13 Ibid., 4.
would marry and raise a family of her own.

Although her family assumed she would eventually have a family of her own, her mother balked at convention by insisting Avery attend college. Her mother, Lou Alyce Munging Reddick England, earned her degree in education at Bethune-Cookman University, an historically black college in Daytona Beach, Florida. According to Avery, her mother was the only college educated member of the family, and began teaching Avery's aunts and uncles. The family did not always view England's education positively, however. As Avery recalls, “it kind of set up a negative thing in my family that kind of goes on today, and it's passed on to a new generation. They don't like it that my mother got educated and they were angry that she was educated and the rest of them were not.”

College rates for black men and women were extremely low when England enrolled at Bethune-Cookman. By 1940, less than two percent of black women and less than one percent of black men graduated from college, and these numbers only grew slightly by the time Avery enrolled. Given the prohibitive cost of a college education, many of the black women able to enroll were wealthier than most, so it was unusual that Avery and her mother, neither of whom came from middle-class families, could afford the tuition. Avery knew from an early age that her mother expected her to succeed academically. Her college ambitions appeared early when she began considering which college to attend in the eighth grade. After reading an article in Ebony magazine, Avery decided to apply to Talladega College, an historically black college in Talladega, Alabama. Once Avery left home for Talladega in 1954, her life changed

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14 Avery interview, 3.
16 As Deborah Gray White notes, one third of black clubwomen, the majority of whom came from middle-class or wealthy families, graduated from college. Thus, although only two percent of all black women completed a higher degree, most of those women came from wealthier families. Deborah Gray White, Too Heavy a Load: Black Women in Defense of Themselves, 1894-1994 (New York: W.W. Norton & Company, 1999), 89.
dramatically, driving her toward health activism.

At Talladega University, Avery became exposed to more volatile racial issues and the Civil Rights Movement. Her involvement in the movement, however, was at most minimal. According to Avery, students were “protected” on Talladega's campus because it was a small town and life centered around the campus. As Avery remembers, many of the students knew about the movement, but it was largely out of sight and out of mind. This feeling changed in 1956 when Autherine Lucy, a black student who worked to integrate the University of Alabama, arrived at Talladega's campus for “safekeeping.”17 According to Avery, racial tensions did not obviously affect students on campus until Lucy's arrival. A number of protesters arrived at Talladega and “we heard shouts from the cars: Authorine's [sic] got to go, Authorine's got to go.”18 This incident, according to Avery was really the first time she began to understand major racial tensions throughout the South, especially in Alabama.

The presence of large numbers of students from Birmingham also brought the movement closer to home for Avery. Many of the students from Birmingham were middle-class and, according to Avery, “real tuned in” to racial tensions and the battles to end racial discrimination. These students from Birmingham “were already signing up to be part of the sit-ins, to be part of the marches in the park in Birmingham.”19 According to Avery, the threats against Lucy, combined with the increased visibility of Birmingham students, let her know “that things were going to continue to get much more volatile. We knew that [the protest against Lucy] was just the

17 Sitkoff, Struggle for Black Equality, 57; “Authorine Lucy Found Living As A Guest At Talladega,” The News and Courier, February 17, 1956, 12B. Lucy applied for graduate school at the University of Alabama in 1952. Denied admittance after the university found out about her race, Lucy re-enrolled in 1956 once the courts ruled that the university could not bar Lucy based on her race. The university eventually expelled her, ostensibly to protect her from the crowds who had gathered for three days to protest Lucy's presence on the campus.
18 Avery interview, 7-8.
19 Ibid., 9.
beginning of it.” However, Avery mostly stayed out of the movement. “I was aware of it. I knew all about it, but I think I was scared,” she recalled of the movement during her years at Talladega.  

Surprisingly, in Avery's eyes, it was the white professors who worked to bring knowledge of the fights for racial liberation onto Talladega's campus. Although there were many politically conscious and important black professors at Talladega, a white psychology professor, Dr. John Bross, exposed Avery directly to the movement outside of Talladega. Dr. Bross was the first Talladega professor who took a group of black students, including Avery, to Montgomery. The group visited Ebenezer Baptist Church, Martin Luther King Jr.'s church, as well as Tuskegee. In fact, “he gave us, like, a whole Southern tour, which – we think nothing of that today, but in the '50s, it was something for a white man to be driving around a whole bunch of black people in a car at that time, especially when the racial tensions were starting to build.” The group faced no problems on their trip throughout the South, but Avery marveled that a white man would take the time and risk to guide Talladega students throughout the South.

Avery also had the opportunity to attend a speech by Martin Luther King, Jr. Avery remembers he was an “incredible speaker” but even this speech did not pull Avery into the movement which still felt distant and unrelated to her. Avery continued to be aware of the major events in the movement, however. Avery's stepfather, her mother's second husband Lonny England, decided he would attend the 1963 March on Washington as a representative of their church. England at first hesitated, but he later “came in and said, No, I'm going to go. I don't care what happens.”  

20 Avery interview, 8-9.
21 Ibid.
22 Ibid., 7.
23 Ibid., 8-9.
ended up going to a couple of rallies after moving to Jacksonville, Florida but “wasn't sitting up on the front row screaming and hollering.” For Avery, by 1963 life often got in the way of participating in the movement.

On Avery's first day at Talladega, she met Wesley Avery, the man she eventually married. Avery describes Wesley as an intelligent man who entered college after receiving a scholarship his Junior year in high school. The two married on June 25, 1960, and had their first child on August 27, 1961. Her son was two years old at the time of the March on Washington and attending marches and rallies seemed almost irresponsible to Avery. Besides, she notes, “I was really thinking about babies and that kind of thing” rather than focusing on racial injustice. Additionally, Wesley made no effort to pull Avery into the movement. As Avery remembers, Wesley was a “nice man, who also, at that time, understood the politics of [the Civil Rights Movement] but wasn't so much inspired.” Feeling disconnected from the movement, with other immediate priorities, neither husband nor wife were particularly invested in the movement.

Issues raised in the Women's Liberation Movement, however, touched Avery closer to home. Reproductive freedom and the availability of birth control methods became critical to Avery as she began her relationship with Wesley. Managing her fertility was important to both Avery and Wesley before and during their marriage. They consciously tried to control their reproduction despite the number of problems Avery faced learning about birth control and its use, problems many black women faced when they tried to control their fertility. Although the couple desired children, Wesley wanted to wait ten years before they had children, and Avery also wanted to hold off on starting their family. The couple, according to Avery, had been “pretty

24 Avery interview, 9
25 Ibid., 7-10.
26 Ibid., 9.
good [at] using condoms. We were real good condom users” before they were married.27 Avery later went to a physician to be fitted for a diaphragm, a method she believed was more effective than condoms. There were a number of problems with this method. Avery remembers her “[physician] didn't fit me properly for it, because it hurt real bad when I put it in” but she continued using her diaphragm because the only birth control methods she knew about “were barrier methods.”28 She had little knowledge of hormonal forms of birth control, leading her to believe the barrier methods were the only ones available. Avery admits that she “didn't know what [she] was doing” and she ended up pregnant with her first child.29 Although Avery does not go into great detail about the physician who fitted her for the diaphragm, she does note “the doctor that I was going to see to ask about birth control was a Catholic, so what do you expect.”30 The couple continued using birth control methods until the birth of Avery’s daughter in 1966. It is unclear whether or not Avery still used barrier methods, but she did use the calendar to map her cycles and her most fertile days. As Avery notes, “I ended up miscounting my cycle and getting pregnant with” her daughter.31 Despite her attempts to exercise her reproductive freedom, Avery found it difficult to control her fertility, a situation shared by many black women. The cost of birth control and abortion, a lack of available information, and racist attempts to constrain their fertility meant that black women were not always in control of their bodies. As scholar Dorothy Roberts argues, the “systematic, institutionalized denial of reproductive freedom has uniquely

27 Avery interview, 13.
28 Ibid..
29 Ibid., 10.
31 Avery interview, 10-12.
marked Black women's history in America.”32 From slave masters' stake in black women's fertility to sterilization abuse in the 1970s, black women consistently struggled, as Avery did, to exercise control over their bodies.33 Avery does not recall how she knew about the barrier methods, but it is clear from her oral history that her physician consciously avoided giving her the information she asked for and even fitted her diaphragm improperly. This lack of options for the couple to prevent pregnancy affected Avery's notion of reproductive justice and freedom later in her life.

**Budding Activism**

1970 marked a major turning point for Avery, both in the development of her activism/political consciousness and in her personal life. On November 27, 1970, Wesley Avery died at age 33 from a massive heart attack. He had been relatively healthy throughout his life, rarely becoming ill, but Wesley was hypertensive. Neither Wesley nor Avery understood the potential ramifications of hypertension, and doctors always treated his high blood pressure as a minor problem. The first time the couple learned about Wesley's hypertension was during an exam before his potential Army induction soon after their marriage. His blood pressure was high during the exam, but the physician had him lay down for thirty minutes. The physician performed the test again and he sent Wesley home with normal blood pressure. The second time a physician mentioned his high blood pressure, the doctor told Wesley he needed to exercise and

diet to help bring his pressure down. Although hypertension is serious and a risk factor for further heart problems, Avery insists doctors did not fully explain the problems of the disease. Although physicians recognized hypertension as a serious illness by the 1950s and had a variety of drugs to treat the disease by the end of the decade, Wesley's physicians did not seem particularly concerned about his high blood pressure.\(^34\) "This is the time before [lay people] started learning about high blood pressure being the silent killer," Avery remembers, "it wasn't put into a way that he would have known that it had the dangers it carried."\(^35\) Approximately nine years after Wesley was first told he was hypertensive he was dead of a massive heart attack, catching Avery and her family by surprise.

Wesley's death threw Avery's personal life into turmoil. Suddenly a single mother with two young children, her husband's death forced Avery to grapple with a number of issues she had never before confronted. Wesley's death, as Avery states, "politicized" her and became a "radicalizing" experience. According to Avery:

here we were, two young black people, already got our college degrees, already got the two kids. We were really ready to take on the world. We were thinking about where did we want to live . . . And that was taken away from us. And I realized it doesn't matter how much formal education you have. If you don't know how to take care of yourself, you're still basically in a state of ignorance.\(^36\)

For Avery, it was Wesley's death, more than anything else, that convinced her that most

\(^34\) Andrew L. Dannenberg, et. al., “Progress in the Battle Against Hypertension: Changes in Blood Pressure Levels in the United States From 1960 to 1980,” *Hypertension* 10 (1987), 226. In the 1950s and 1960s, physicians generally used diuretics to treat patients with hypertension, a therapy which was largely effective in controlling blood pressure.

\(^35\) Avery interview, 11

\(^36\) Ibid.
Americans existed in a state of ignorance about their health and health care. If she or Wesley had been better informed, they might have better understood the potential dangers of hypertension and might have worked to improve his health so that his life would not have ended at such a young age from a controllable illness. As Avery noted, intelligence and education had little to no effect on the health status of members of her husband's family, many of whom had advanced degrees. Education did not mean that one understood the ramifications of diseases, especially when kept ignorant by those in the medical community. Her father-in-law died at 57, her brother-in-law at 40, and her sister-in-law also died at a young age, all from controllable or preventable illnesses such as diabetes and cardiovascular disease. At this point, as Avery remembers, she began wondering whether it was social influences and personal decisions which caused such early deaths. “I looked at other things about how we make decisions about our life,” Avery recalls, “that [health] has a lot to do with how we're reared, what we eat, what foods they love, what habits we're into, how hard they are to break – how change is just very difficult.”

It was this thought— that perhaps health status is far more complicated than most people realize—that pushed Avery toward a lifetime of health activism.

Avery did not jump head first into health activist organizations, however. Her foray into political action, rather, began with reproductive health and the feminist movement. After Wesley's death, Avery began turning to her colleagues at the Children's Mental Health Unit in Jacksonville, Florida for guidance and support. Paul Adams, a pacifist and a Quaker, headed the unit and urged Avery to consider the future and continue pushing forward with her life. Soon after Wesley's death, Adams asked Avery and two colleagues, Margaret Parrish and Judy Levy, to make a presentation on reproductive health for the next didactic seminar hosted by the unit.

Avery interview, 11.
Adams asked the women to speak about what was happening in the larger movement for reproductive health and reproductive justice. Avery found herself anxious about the presentation given not only her own lack of knowledge about birth control, but also because the seminar would have to cover abortion.

“I was scared to talk about abortion,” Avery remembers “because what was my mother going to say?” 38 Although the Supreme Court handed down the Roe v. Wade decision only two years later in 1973, Avery still felt apprehensive about approaching such a controversial topic. “I didn't know anything about abortions. In my life that word couldn't even be mentioned without having somebody look at you crazy,” Avery recalls. 39 Avery was not alone in her discomfort and hesitancy to discuss abortion. Although numbers of black feminists were hard at work in the movement for abortion's legalization, as historian and activist Loretta Ross notes, many black women who did not necessarily view themselves as feminists hesitated to discuss abortion openly. Fearful of criticism from some black male activists who associated abortion with black genocide and viewing abortion as a primarily white woman's concern, many black women, according to Ross, avoided discussing abortion openly. 40 Despite their initial discomfort, Avery, Parrish and Levy put the presentation together, discussing where abortion was legal as well as the court cases affecting abortion's legal status throughout the country. After their presentation, many Gaineseville women identified Avery, Parrish, and Levy as people who could help women

38 Avery interview, 14-15.
get abortions since they had spoken publicly on the topic. They knew very little about how to help women in Florida, where abortion was illegal, find an abortion provider, however.\textsuperscript{41}

Avery noticed fairly quickly that most of those who contacted herself, Parrish, or Levy seeking abortion providers were white. Eventually, after a number of inquiries, the three women began calling around and located the Clergy Consultation Service on Abortion, a New York based network of clergy who referred women to abortion providers, and found a provider in New York. The cost of a legal abortion was prohibitive. A women seeking an abortion in New York had to pay for a flight on top of the fee for the procedure. Despite the cost, many white women were more than willing to pay to have a legal abortion in New York. Avery, Parrish, and Levy soon encountered a problem when a black woman contacted them. Avery tried to give her the number for the New York provider but the woman “looked at us in awe” and “said she didn't need no telephone number in New York. 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.”\textsuperscript{42} Many of the white women seeking abortions in Gainesville were middle-class or wealthy university students, most of whom were able to secure enough money to fly to New York. It is likely that wealthy and middle-class black women could also afford the cost of a legal abortion, but poorer women found the cost prohibitive. The black woman who called Avery, Parrish, and Levy was unable to afford the expensive trip to New York and later died from a self-induced abortion. Avery realized that, while reproductive health and abortion were topics which impacted all women, they affected black and white women differently. Avery notes she began to understand that “it's not only just having it [abortion] available, it has to be accessible.”\textsuperscript{43}

\textsuperscript{41} Avery interview, 14-15.  
\textsuperscript{42} Ibid., 15; Avery, “Breathing,” 5.  
\textsuperscript{43} Avery interview, 15.
The experiences of helping women find abortion providers spurred Avery to begin participating in the feminist movement. Many women in Gainesville started forming consciousness-raising groups, the organizing backbone of the Women's Liberation Movement, and Avery began participating in the groups which were predominantly white. Generally, these were small groups made up of women who would gather together to discuss their experiences as women and the effects of sexism within their lives. The purpose of consciousness-raising groups, according to writer and scholar Anita Shreve, was to help women achieve what was called “the click.” According to Shreve, this “click” was:

the sudden comprehension, in one powerful instant, of what sexism exactly meant, how it had colored one's own life, the way all women were in this together. It was that awe-inspiring moment of vision and of commonality, when a woman was instantly and irrevocably transformed from naïve to knowing, from innocent to experienced, from apolitical to feminist.44

The groups, though interesting to Avery, did not necessarily initiate the “click” in her. She did not experience a transcendent moment which transformed her into a feminist at this point. The consciousness-raising groups introduced her to the central process of the feminist movement, but these groups were not critical to her activism and feminist revolution. Rather, it was the feminist classic, Betty Friedan's *The Feminine Mystique*, which helped develop her feminist consciousness. Despite black feminist critiques of the work and its meaning in the lives of most


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black women, Friedan's critique of American society really hit home with Avery. In particular, Friedan's description of the “problem that has no name,” a malaise brought on by a life of housework and child-rearing with little career advancement and emotional fulfillment hit home with Avery. During their marriage, both Avery and Wesley worked outside the home, but she would come home to work a second shift: she would cook dinner, clean the house, and take care of their children while Wesley would relax, watching TV or reading. Wesley began recommending that Avery take a look at Friedan's work but, because of her anger that he was able to relax while she continued to work, she refused to read it. However, after Wesley's death, she read the book which “really opened my eyes, and I could not close them again.” Avery felt Friedan's work spoke to her directly, describing the thankless work she put in at both home and the office while her husband relaxed. Up to Wesley's death, Avery's life focused almost solely on her husband and children. After being touched by The Feminine Mystique, however, Avery could no longer ignore her desire for something more.

After Avery's “incredible awakening,” she joined with her friends and began sitting in Judith Levy's kitchen reading every feminist text they could get their hands on and dreaming about the possibility of opening up an abortion clinic in Gainesville so no woman would have to travel long distances for treatment. Their commitment to opening a comprehensive abortion clinic became stronger after the women attended a meeting hosted by feminist activists Carol Downer and Lorraine Rothman. The two women traveled throughout the United States teaching

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45 For example, feminist scholar bell hooks criticized Friedan for believing the experiences of white, college-educated housewives was “an adequate reference point by which to gauge the impact of sexism or sexist oppression on the lives of women.” The universalizing of white women's experiences troubled hooks as well as many other black feminists. She does not criticize Friedan for discussing the problems of these women, but she does criticize Friedan for assuming that sexism affected all women similarly. bell hooks, Feminist Theory: From Margin to Center (Boston: South End Press, 1984), 2-3.

46 Avery interview, 16.
self-help gynecology, showing women how to view their own cervixes. Avery, Parrish, and Levy attended the meeting, joining other women in learning how to view their cervix with the help of a flashlight, a speculum, and a mirror. According to Avery, Rothman and Downer taught women “that we needed to make sure that we knew what the doctor was looking at and we needed to know how to take care of our bodies.”47 For Avery, the meeting and viewing her own cervix was an awe-inspiring moment. “That [viewing her cervix] was an act that would get you- that is one of the things you will remember where you were. You will remember when you did it. It was of that importance.”48 Physicians generally kept women ignorant about their bodies, and few women knew much about their reproductive organs. Wielding a speculum, the physician's tool, and examining their bodies was an act of rebellion for many women which had the added benefit of teaching them about their bodies. Viewing their cervixes led Avery and some of the other women at the demonstration to decide to open up a comprehensive women's health center which would perform abortions, but would also provide the same sort of awe-inspiring and radicalizing experience for women who had not attended a self-help gynecological meeting.

The group, including Margaret Parrish, Judith Levy, Betsey Randall-David, and Joan Edlson, decided they needed to open such a center but also recognized the myriad problems in trying to found an abortion center. According to Avery, the Alachua County Medical Society had worked actively against Planned Parenthood's plans to open up a clinic. In order to avoid controversy, the group worked quietly and quickly, finding a medical director and acquiring a facility across the street from the local hospital. The women borrowed money and solicited donations, some even pooling their own money, raising enough money for aspirators (purchased

47 Avery interview, 18.
48 Ibid.

37
from the Clergy Consultation Service on Abortion), furniture, and decorations.49 The facility opened its doors in May of 1974.50

The Gainseville Women's Health Center became more than just an abortion provider. Like the other Feminist Women's Health Centers, the Gainseville Center “taught the women everything in the world they wanted to know or didn't want to know about their bodies. We were not passing up this opportunity to educate.”51 They helped their patients view their own cervices, discussed birth control options, and even provided well-woman gynecological care such as pap smears. The Center also hosted education workshops, including a workshop on sexuality and masturbation taught by sex educator and author Betty Dodson. This workshop was particularly memorable and meaningful for Avery, who recalled Dodson “had us all looking at our vaginas and looking at each other's vaginas and I really didn't – had never thought about the fact that everybody's whole vaginal area looks different, just as our faces look different. And none of us knew that ours was so beautiful.”52 Learning about her anatomy and celebrating differences was a revelatory experience for Avery and the other members of the Gainseville Women's Health Center. This education and celebration of women was an integral part of the center's operation.

The members of the center found a great deal of freedom in their work. They explored a number of activities which were not traditionally understood as health care, and definitely not part of women's health. Practicing yoga became common, and many members learned massage as both a relaxation technique and a way of celebrating the human body. The women began charting their menstrual cycles, embracing the cycle instead of dreading and cursing the arrival

49 Vacuum aspiration is one of the most common abortion procedures. It involves dilating the cervix then passing a cannula (or small plastic tube) into the cervical canal and attaching a vacuum which removes the uterine lining and any possible embryo.
50 Avery interview, 16-17.
51 Ibid., 17.
52 Ibid.
of their periods. Ultimately, according to Avery, time spent working at the Gainesville Women's Health Center “really sort of gave ourselves permission to learn who we are, to explore who we are to the fullest. And it gave us such a sense of pride.” For Avery, the confidence in her abilities and the relationships she was building with other feminists spilled over into other aspects of her life, adding to the growing feeling that there was more work to be done.

Despite the feminist politics guiding the activities of the Gainesville Women's Health Center, the founders occasionally found themselves at odds with other members of the Federation of Feminist Women's Health Centers (FFWHC). Downer and Rothman formed the organization, a grouping of women-owned and women-controlled health centers, in the 1970s as a way to expand their goal of wresting control of women's bodies out of the hands of physicians. The FFWHC provided abortions and other gynecological services to women under the banner of self-help. FFWHC founders “set out to create an organization and feminist clinics that espoused a unified ideology and identifiable politics, in effect to build a movement-within-the-movement.” The first women's health center formed in Los Angeles, and their ideology and system of care spread throughout the United States and into Florida (specifically Tallahassee) in 1974. As the FFWHC began growing and pulling in more FWHCs, standardization of care became crucial to FFWHC leaders. With standardization they could promise that all women, no matter where they received care, could expect a certain standard based on feminist principles. According to the FFWHC, it was “founded on the principle that we agree on our political strategy, our goals, and our internal workings. We are accountable to each other.” For FWHCs, then, this meant the FFWHC could try and exert their influence over centers they believed acted

53 Avery interview, 17.
55 Ibid., 100.
contrary to the strategies, goals, and workings of the FFWHC.

While insisting independent centers follow FFWHC policy may have standardized care for individual women, it placed these centers in an awkward position if they disagreed with aspects of standardized care. If the majority of FWHCs in the federation believed an individual FWHC was not acting in accordance with the goals and ideology of the larger group, there could be conflict. In 1974, for example, FWHCs in Tallahassee and Detroit signed a resolution, published in a feminist newspaper, that the Oakland center was not a FWHC because of some of their political activities. Later, the Tallahassee center left the federation after a dispute with Carol Downer over their own politics. Forcing FWHCs to fall in line with group policy made disputes between individual centers and the federation inevitable. The Gainesville Center had its own share of problems with some of the FFWHC policies. The center had a closer relationship with the Tallahassee FWHC than any other center but, according to Avery, “they were a lot more hard-nosed feminists than we were.” For the women at the Gainesville Center, sticking to the FFWHC “rules” was less important than doing what they believed worked for the center and the women they served. Many of the other FWHCs, Avery argues, “were very – you know, stuck to the rules, and you could only use a certain size cannula for the abortion, and they had very strict rules,” while the Gainesville center “did more of a blend of things that we thought were good.”

Although the Gainesville Center remained in the FFWHC, this was one of the first instances of conflict between the center and the FFWHC.

The Gainesville Center's beliefs conflicted with FFWHC policy around the issue of menstrual extraction. The procedure, which allowed laywomen to remove the contents of the uterus, became possible in 1971 with the development of the Del-'Em jar. The menstrual

56 Avery interview, 18.
extractor, developed by Lorraine Rothman with help from Carol Downer, was, in essence, a simpler version of the vacuum aspiration equipment used by abortionists. However, Rothman and Downer did not publicly advertise menstrual extraction as an abortion technique. Rather, “it was touted as a means for women to reduce the length and discomfort of their menstrual periods.”57 As a menstrual extractor, the Del-'Em jar removed the entire contents of a woman's uterus, including any embryos that may had implanted in the uterine lining. Although Downer and Rothman did not acknowledge to anyone other than FFWHC members that menstrual extraction could abort an embryo, few in the medical community missed the abortive implications of the procedure.

Promoting menstrual extraction as a way to abort a pregnancy without physician aid, and as a way for a woman to take control over her menstrual cycle, was one of the more controversial activities of the federation. Although the FFWHC insisted the procedure was safe, they also cautioned that adequate training was crucial to the procedure's safety. Despite the FFWC's assurances, Avery and others at the Gainesville Center had their reservations. Despite the claims of safety, Avery feared the procedure could have unintended side effects or that women might be harmed in the process. “We didn't know whether you would pull off some of the lining” of the uterus, Avery recalls.58 The Gainesville workers did not trust that the procedure was as safe as the FFWHC claimed. More importantly, however, were the reservations Avery and others had over the reasons for menstrual extraction.

The Gainesville Women's Health Center supported abortion rights and fought for safe, cheap, accessible abortion facilities. Menstrual extraction, however, was not merely a form of

58 Avery interview, 18.
abortion. Avery and other workers disagreed with the position that menstrual extraction was an important way for women to gain control over their menstrual cycles. The women at the Gainesville center understood their cycles differently. Instead of an uncontrollable nuisance which women needed technology to control, the approach of Avery and the other women in Gainesville “was we were making peace with our menstrual cycle. We didn't want to get rid of it in one quick thing. We wanted to know how to live with it in harmony and deal with the fact that some of us have bad cramps, some of us have other things that make it not so positive. But we were more interested in turning it into a positive experience.”59 For Avery, making peace with one's menstrual cycle, and accepting one's body and its processes, was crucial to living a calm and happy life. Although menstrual extraction might give a woman control over her period, this control was not, necessarily, something to be lauded. This sense, that many in the larger Women's Health Movement viewed women's bodies and their natural processes as something one needed to control, fueled Avery's growing sense that something was not right in the movement.

While at the Gainesville Women's Center Avery began to recognize how few black women took advantage of their services. She noted a disproportionately high number of black women contacted the center for reasonably priced abortions, while few took advantage of the other services. In Avery's opinion, it was the Hyde Amendment, a 1977 rider attached to an appropriation bill which outlawed the use of Medicaid funding for abortions, which pushed many poor women into the doors of the center. Avery noted the Hyde Amendment was a measure directly targeting poor women and, by extension, black women. “For poor women abortion is a matter of survival: if I have this one more child, it etches away my margin of survival,” Avery argued. Thus, “taking away Medicaid funding says to poor women, 'you can't have this-you don't

59 Avery interview, 18.
deserve to have this.” Avery praised the center for being able to provide abortions, at a low cost, for poor women whose primary insurance could not cover the procedure.

Avery also wanted black women to take advantage of the well-woman gynecological care and the birth control services the center provided. Noting that black women too often had to place their own health on the bottom of their priority list, Avery endeavored to establish a model of health care and services which could directly serve black and poor women. The fact that both the center and the larger women's health movement were largely unable to reach black women troubled Avery. Although the center advertised their well-woman gynecological clinic in the church bulletins of predominantly black churches in the area, they still did not have large numbers of black women utilizing their services. Although they ran the clinics at nights and at low cost, “we still didn't get the population coming in.” Rather, it was mostly young white women from the University of Florida who drove to Gainesville, using the center as an alternative to the traditional health centers available to them. “They were coming and getting all the information,” Avery remembers. “It was fine for them to get it, but we also wanted other folks to get it too.” Unfortunately, the center was never able to bring in larger numbers of black women. Despite Avery's disappointment in the center's apparent failure in bringing in black women, and her growing belief that the movement had to change in order to help black women, the center dedicated itself to providing care to the white women at their clinics. Fairly quickly, however, these same women began pushing the Gainesville center to consider other women's health issues, especially childbirth, pushing Avery and some others at the Gainesville center toward founding an alternative birthing center, Birthplace.

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60 Silliman, Undivided Rights, 65.
61 Ibid.
62 Avery interview, 17.
63 Ibid., 16-17.
**Birthplace**

While at the Gainesville center, white women began taking an interest in their birthing experiences, many of which had been wholly negative. By the 1970s, many women's health activists began to critically examine birthing practices throughout the United States. Historian Wendy Kline describes how throughout the 1970s, more and more women, especially white women, demanded a birthing experience where they were awake, aware, and in control.64 Countless women discussed birthing experiences with physicians who ranged from neglectful to hostile. Women were drugged, strapped to birthing tables, and chastised for cursing in response to their pain. Physicians expressed their anger over women attempting to control their birthing experiences, believing they had no right to usurp the authority of the trained physician. This desire to transform childbirth from a medical event into a natural one, and the hostility from many physicians, pushed many women to seek out birthing experiences with trained midwives (the vast majority of whom were women) and to seek out birthing centers separate from traditional medical institutions.

As this desire for “natural” childbirth spread amongst women throughout the nation, white women began discussing birthing alternatives with workers at the Gainesville Women's Health Center. According to Avery, these women began questioning their doctors, criticizing the way they were treated during pregnancy and birth, and where they should be giving birth. During this period of questioning, and discussion with health workers, many clients decided they wanted to have their babies at home attended by midwives. They began asking the center for midwife recommendations and asked if the doctors doing the abortions would check on the babies after

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their birth. These women wanted to extend feminist health care past abortions and well-woman gynecological care and into a different stage of their reproductive lives.

This desire fell in line with Avery's dream of providing more complete care for women. Almost immediately, after learning more about abortions and gynecological care, Avery states she and others realized “that we are women with a total reproductive cycle.” The Gainesville Center wanted to develop a “reproductive health experience that was a total experience that showed that we have certain needs at different stages of our lives and certain decisions make sense then.” Providing yearly pelvic exams and abortion services were crucial, but women needed care which extended into and beyond their pregnancies. Given the demands for prenatal and obstetrical care, it made sense to Avery and others to extend their work into a birthing center.

Opening such a birthing center, however, became far more complicated than Avery anticipated. As the Gainesville center staff discussed the possibility of hiring midwives, conflicts began arising amongst the staff and board at the Gainesville center. There were individual conflicts with Judith Levy, whose brusque style of leadership frustrated many workers. Numbers of workers felt alienated by Levy despite her intelligence and able leadership. Although Avery is not forthcoming in her discussion of the conflicts between the staff, she does note “it [the conflict] probably was power and not understanding how to handle power- [a] power struggle.” In order to bring peace to the center, and ensure it would not suffer the same problems as some of the other FWHCs, Judith Levy, Margaret Parrish, and Byllye Avery opted to leave the center.

They gave up their seats on the board and took the idea of an alternative birthing center, Birthplace, with them. The experience was painful for Avery, but the fact that the center did not

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65 Avery interview, 20.
67 Avery interview, 20
68 Ibid., 20-21.
ultimately suffer because of the conflict gave her a sense of peace.

After forming the Gainesville Women's Health Center, Parrish, Levy, and Avery understood how to go about opening a new health facility which might directly impact traditional physicians' practices. Four years earlier, the women managed to open the Gainesville Women's Health Center without permission from the Alachua County Medical Society. “We acted like we were dumb women and didn't ask them,” Avery recalls, because they knew the medical society would be hostile to the center. Ultimately, they convinced the society to support Birthplace and they worked to raise money and find a facility. The women solicited donations from individuals throughout Gainesville, asking for $1,000 loans which they planned to pay back with interest. They were so successful that, in one afternoon of fund-raising, they managed to raise $16,000, more than enough to get started. They found a former Methodist parsonage which was large enough to accommodate the center and they begin begging stores and individuals for furniture and decorations. Once the facility was ready, they hired a midwife from Fort Myers, Florida, Nancy Redfern, who opted to live at Birthplace.69 Once they found their midwife, they were ready to begin taking in women. Birthplace opened its doors in 1978.

Avery's position within Birthplace was as the public relations and education expert. She helped couples and expectant mothers begin their orientation at the facility, and she also spread news about the facility in the community. One of her goals as she advertised Birthplace was to attract black women to the facility while also convincing younger black women to consider becoming midwives. Black midwives played a critical role in black communities throughout much of America's history. Midwives, historian Susan L. Smith argues, were a vital link between poor black women and children and traditional health care facilities and providers, often

69 Avery interview, 21.
providing care outside their traditional midwifery duties.\textsuperscript{70} Midwives provided health services to the poor and children while also educating the entire community on their health. They also helped traditional medical workers promote clinics and immunization programs and encouraged women to seek pre- and post-natal care from licensed medical providers.\textsuperscript{71} Black midwives had a long-standing and important place in the health care of black communities, a fact which Avery recognized. While at Birthplace, she endeavored to draw attention to the importance of black midwives in health care delivery in black communities.\textsuperscript{72} Encouraging black women to become midwives might ensure more black women would have access to pre- and post-natal care, Avery believed, since many midwives would provide care at a lower cost than physicians. In addition, Avery wanted to bring more black women into the profession, empowering them both economically and politically. Although Avery had a difficult time encouraging black women to become midwives, the idea that black women needed to become more directly responsible for their own health care, and the care of their communities, remained in the forefront of Avery's mind.\textsuperscript{73}

Along with encouraging more women to become midwives, Avery and the other workers at Birthplace attempted to create an environment which stressed “the importance of being involved in our own health.” Birthplace staff endeavored to create a positive environment where women could be excited to receive medical care. This type of environment, which was positive, supportive, and empowering, was crucial for health care because it made women excited to seek


\textsuperscript{71} Ibid., 118.

\textsuperscript{72} Silliman, \textit{Undivided Rights}, 66.

\textsuperscript{73} According to Avery, many black women were not interested in becoming midwives because they associated midwives with poverty. Despite midwives' historical importance in black communities, Avery argues, many black women viewed "granny midwives" negatively, desiring to give birth in hospitals rather than at home.
out prenatal care. According to Avery, care during a woman's pregnancy was one of the only long stretches of time when “a woman comes on a continuous basis.” For this reason, “that [pregnancy] is the time to start affecting her life so that she can start making meaningful lifestyle changes.” Extended periods of care are uncommon for most women, outside of their pregnancies, and Avery recognized this was a critical period for convincing women to take control of their health care both during and after their pregnancies. Avery believed providing care during pregnancy, a traditional form of women's health care, might empower women to begin demanding better and more respectful health care after their child's birth. Perhaps more importantly, however, this empowerment might spread into other avenues of a woman's life, giving her the power and confidence to begin making important changes in her life such as leaving abusive relationships or seek out additional education. As Avery noted, “health provides us with all sort of opportunities for empowerment.”

What kind of prenatal care, however, might be able to bring about such changes in a woman's life? And, how could a such a program empower women of differing races and economic backgrounds? These were the questions Birthplace tackled in the development of a prenatal program. Although issues of difference changed the prenatal experience for individual women, certain issues seemed to cross racial and economic lines. Avery and the other Birthplace staff noted all women need a support group during their pregnancies. In their prenatal program, a woman would enter into a group during each visit, leave for her physical checkup, then return to the group when this exam was finished. This meant that Birthplace clients would not have to wait, separated from one another, in a cold, sterile waiting room. The experience of prenatal care was meant to bring women together to support each other, according to Avery. “Most of these

74 Avery, “Breathing,” 5.
women have nobody to talk to,” Avery notes. “No one listens to them; no one helps them plan.” However, many pregnant women were not taking advantage of a largely untapped source of support: each other.

Avery was aware that there were racial and economic barriers to female solidarity at Birthplace. The majority of the women who utilized the alternative birthing center were white and economically secure. Because of their economic privilege, few of these women worried about common concerns for poor women. As Avery notes, poor women often asked “‘Who's going to get me to the hospital if I go into labor in the middle of the night, or the middle of the day, for that matter? Who's going to help me get out of this abusive relationship? Who's going to make sure I have the food I need to eat?’” Privileged women also worried about their birthing plans or abusive relationships, but these concerns become magnified under the microscope of race and class. The program, although revolutionary and effective for the privileged, did not have much of an impact on black and poor women. The program needed to work effectively for the clientele, the majority of whom were white and privileged. Few black and fewer poor women received prenatal care or gave birth at Birthplace. After inquiring about this discrepancy, Avery learned that most public insurers, including Medicaid, did not cover out-of-hospital births, and the cost of a personalized birthing experience was out of reach for most poor women. Women of means in Gainesville, the vast majority of whom were white, could make the decision to seek out alternative birthing centers. The poor women of Gainesville, who were mostly black, did not have the economic power to make such a decision. Avery's frustration with the lack of a responsive program for black women began growing.

75 Avery, “Breathing,” 5.
76 Avery interview, 6.
77 Silliman, Undivided Rights, 66.
In 1979 Avery made the difficult decision to leave Birthplace. The center needed another midwife to handle the growing numbers of clientele and Avery had no interest in becoming a midwife. In order for the center to survive, they needed to make a choice: another midwife or Avery. She made the decision to leave and took a job working in the CETA program at Santa Fe Community College in Gainesville, Florida. CETA, the Comprehensive Education and Training Act, was legislation designed to train lower income and unemployed students and individuals for higher paying jobs. Throughout her first two years as the CETA personnel and workers' liaison, Avery came face-to-face with many young black women.\(^{78}\) Throughout her years as an activist in Gainesville, Avery had been spending the majority of her time with other activists, the majority of whom were white. She had had little experience with other black women despite her attempts to reach out to women in the local community. Her position at Santa Fe Community College gave her the opportunity to ask young black women about a number of troubling issues.

Through her contact with the students in the program, Avery became concerned about high levels of absenteeism among the black students. They were being paid minimum wage to come to school and Avery wondered why that was not enough of an incentive, or if there were other issues getting in the way of their attending classes. It was a nineteen-year-old young woman in the CETA program who finally pushed Avery to confront some of the young women. This young woman had at least three children and was rarely present in her classes. Avery confronted the young woman asking, “Explain this to me. How did this happen? Do you know?” And she said, 'Well, my mama had me when she was 12 or 13, and so, I wanted to get out. I was taking care of her children. I wanted to get my own place. So the way to get my place was to

\(^{78}\) Avery interview, 23-24.
have a baby.” Having multiple children at a young age freed her from her mother's home, but trapped her in other ways. Avery continues:

when any of these kids got sick, or any of these kids had a problem, she couldn't come to work- she couldn't come to school. I found out that they had a lot of health problems, that they were diabetic, they were hypertensive. They just had problems at such an early age, much earlier than I thought we get things. And so, that was very eye-opening to me.

The experiences of many of these young women were foreign to Avery, but they affected her deeply. She began bringing together young black women in the CETA program to discuss their lives and experiences in the hope that they might be able to support each other.

Avery had finally experienced the “click” she had not felt in her consciousness-raising groups years earlier. Avery then began “to look at myself as a black woman. Before that time I had been looking at myself as a woman.” Although Avery clearly understood the affects of racism in her life, the majority of her past activism focused on sexism and its affect on women. In Avery's mind, at least until this point, the effects of sexism played a more central role in her life. As years of activism showed, however, black women experienced sexism differently than many white women. Although Avery had slowly been coming to recognize this fact, it was when she began discussing these issues with other black women that she experienced the “click.” As Avery notes, “it was there [in these groups of black women] that I started to understand the lives

79 Avery interview, 24.
80 Ibid.
of black women and to realize that we live in a conspiracy of silence."\(^82\) Black women, according to Avery, were not encouraged to speak to one another about personal issues, including their health concerns. Avery's conception of a conspiracy of silence is similar to historian Darlene Clark Hine's discussion of the culture of dissemblance amongst black women. According to Clark Hine, in order to survive in a racist and sexist society, black women “adhered to a cult of secrecy, a culture of dissemblance, to protect the sanctity of their inner lives. The dynamics of dissemblance involved creating the appearance of disclosure... while remaining an enigma.”\(^83\) Upholding this veil of secrecy, according to Clark Hine, helped create a space for black women to “create alternative self-images and shield from scrutiny these private, empowering definitions of self.”\(^84\) Discussing one's private life, including highly personal issues of health and sexuality, could be used to support negative stereotypes of black women. Thus, as Clark Hine shows, dissemblance helped protect black women's inner lives, allowing them to create a new vision of black womanhood. This secrecy and silence, however, meant that black women rarely discussed these issues with one another, a silence that Avery found troubling. Once Avery recognized this conspiracy of silence and came into her racial and feminist consciousness, her activism would take yet another turn.

**The National Black Women's Health Project**

Throughout Avery's years of work at the Gainesville Women's Health Center and Birthplace, she was also hard at work as a board member of the National Women's Health Network (NWHN). The organization, founded in 1975 and incorporated as a non-profit organization in 1976, became one of the first, and most powerful, women's health organizations

\(^83\) Darlene Clark Hine, “Rape and the Inner Lives of Black Women in the Middle West,” *Signs* 14, 4 (Summer, 1989), 915.
\(^84\) Ibid., 916.
in the country.\textsuperscript{85} The NWHN was the brainchild of both Barbara Seaman, journalist and author of \textit{The Doctor's Case Against the Pill}, and Belita Cowan, journalist and activist investigating diethylstilbestrol (DES), a pill prescribed to young women as a contraceptive after unprotected sex as well as pregnant women experiencing morning sickness. Seaman and Cowan, who became fast friends, began discussing a Washington based organization dedicated to women's health issues. The friends joined with three others, psychologist Phyllis Chesler, physician Mary Howell, and Alice Wolfson to found the NWHN.\textsuperscript{86} The founders wanted the organization to become

a watchdog of federal health policy; an information clearinghouse that worked to assist its members to be informed health care consumers; and

a forum to bring representatives from a wide variety of grassroots health organizations, health advocacy groups, medicine, nursing, and medical and health care research together on behalf of improving women's health.\textsuperscript{87}

This idea was revolutionary; other groups existed to provide women with health information, but the NWHN would both provide information as well as policing federal health policy. Within just a few years of its founding, the NWHN became one of the most visible, and most powerful, women's health organizations in the United States.

From the beginning, NWHN members believed it needed to address the unique problems of ethnic and racial minorities. At a 1976 meeting, fifty NWHN members worked to identify key issues and develop policy recommendations. This task forced made recommendations in a variety of areas including maternal and child health, rape, women's health rights, women as

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\item \textsuperscript{85} Ruzek, \textit{Women's Health Movement}, 156.
\item \textsuperscript{86} Morgen, \textit{Into Our Own Hands}, 10.
\item \textsuperscript{87} Ibid., 31.
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health care providers, and the special concerns of the elderly, the disabled, and ethnic/racial minorities.\textsuperscript{88} The NWHN was one of the few women's health groups at the time which consciously sought relationships with women of color, and worked toward a racially diverse board of directors.\textsuperscript{89} The NWHN counted among its board members Latina physician and activist Helen Rodríguez-Trías, labor activist Dolores Huerta, and African-American activist and feminist Pam Freeman. This racial diversity, however, did not extend into the NWHN's membership base which remained predominantly white.

Avery joined the board of the NWHN in the mid-1970s, inspired by the organization's supposed commitment to issues for women of color and its diverse board. She worked closely with the board while still acting in her local communities. The experiences she gained at the CETA program, and forming relationships with young black women, convinced her to approach the NWHN with an idea. While at a board meeting in Ann Arbor, Michigan in 1980, Avery approached Norma Swenson, a NWHN board member and co-founder of the Boston Women's Health Book Collective, with the idea of writing a report on black women's health for the board because “I've been coming to all their meetings and nothing had been put down on black women's health. And there were only two black people on the board.”\textsuperscript{90} The NWHN's stated commitment to women of color did not always translate to action, which troubled Avery. While Avery praised the presence of black women on the board, which Avery praised, she criticized the NWHN for failing to recognize and address the needs of women of color. Swenson and the other board members gave Avery their support, and she quickly began researching black women's health.

\textsuperscript{88} Ruzek, \textit{Women's Health Movement}, 156-157.
\textsuperscript{89} Silliman, \textit{Undivided Rights}, 65.
\textsuperscript{90} Avery interview, 24-25.
The process of writing even a brief paper for a planned hour-long presentation on black women's health proved to be an arduous task. Avery began collecting every book on women's health and African American health and what she found, or more importantly what she did not find, deeply troubled her. Avery writes:

I was angry-angry that the people who wrote these books didn't put it into a format that made sense to us, angry that nobody was saying anything to black men or to black women. I was so angry I threw one book across the room and it stayed there for three or four days, because I knew I had just seen the tip of the iceberg, but I also knew enough to know that I couldn't go back. I had opened my eyes, and I had to go on and look.\textsuperscript{91}

Simply put, African Americans, but especially black women, were largely invisible in medical texts. This lack of visibility was so pronounced that, too often, the medical community treated black men and women as study subjects without acknowledging their status as a study subject.\textsuperscript{92} Their lack of visibility angered Avery, but the brief mention she did find concerning black women horrified her. Avery managed to access a 1979 book of health statistics published by the U.S. Department of Health and Human Services. The book showed one startling statistic for black women: over fifty percent of black women between the ages of eighteen and twenty-five

\textsuperscript{91} Avery, “Breathing,” 6-7
\textsuperscript{92} Not only did physicians and researchers not often acknowledge they used black men and women as medical subjects, they also did not always inform patients that they were study subjects. The Tuskegee syphilis study is the most famous, but not the only, study where black Americans were not informed about their status as study subjects. See Susan Reverby, \textit{Examining Tuskegee: The Infamous Syphilis Study and Its Legacy} (Chapel Hill, NC: University of North Carolina Press, 2009); \textit{Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study}, ed. Susan Reverby (Chapel Hill, NC: University of North Carolina Press, 2000); James H. Jones, \textit{Bad Blood: The Tuskegee Syphilis Experiment} (New York: The Free Press, 1993); Harriet A. Washington, \textit{Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present} (New York: Doubleday, 2006); Skloot, \textit{Immortal Life}. 55
reported they lived in a state of psychological distress. This level of distress was even greater than white women of the same age who had been diagnosed with a mental disorder.\textsuperscript{93} Additionally, black women reported the lowest level of positive well-being among all groups surveyed: 70\% of white men reported a positive sense of well-being compared to 37\% of black women.\textsuperscript{94} Additionally, statistics showed that black women had disproportionately high rates of hypertension, diabetes, cervical cancer, HIV, and lupus compared to white women of all classes, and black women died earlier and more often of nearly every serious disease, especially heart disease and most cancers.\textsuperscript{95} These statistics horrified Avery who acknowledged that an hour-long presentation would not be nearly enough to address the dismal health status of black women. The NWHN would have to make black women a priority in order to understand the factors causing these health problems, Avery believed, and she began pushing the Network to support a program focusing on black women's health.

Avery abandoned the one hour presentation and began developing a proposal for a Black Women's Health Project for the NWHN. The proposal listed a three pronged approach to improving the health status of black women: Awareness/Recruitment, Education, and Networking. The project promised to begin a campaign to increase the numbers of black women within the NWHN while also facilitating the “development of linkages between Local and National Black Women's Organizations and the National Women's Health Network and the


\textsuperscript{94} “Fact Sheet,” \textit{National Women's Health Network Newsletter} 7 (January/February, 1982), 6.

\textsuperscript{95} Avery, “Who Does the Work,” 572. Statistics show that 1 out of every 4 black adults (including women) were hypertensive. Cervical cancer rates for black women had steadily increased while white women's rates were decreasing. Cancer survival rates for black women were lower at all stages, even when detected early. Diabetes death rates rose for black women while the white rate decreased.
Building these linkages and coalitions between black women's organizations and the NWHN was crucial to the NWHN given the relative lack of black women within the organization.

The support of the NWHN proved crucial to the development of the the project within the organization. The Network agreed to provide some financial support and to aid in Avery's efforts to find outside financing. Belita Cowan, the director of the NWHN, assisted in Avery's efforts to secure funding, accompanying her to the Ford Foundation's offices in New York City. Although the Ford Foundation ultimately decided not to fund the project, Cowan then introduced Avery to both the Ms. Foundation and the Joint Center for Foundation Support who eagerly promised monies to the new project. Two women at the organizations, Julia Scott and Adisa Douglas, were particularly keen on the project, cheering Avery down the path of improving black women's health. The NWHN proved critical to the building of these financial relationships; their support opened funding doors for Avery and the infant Black Women's Health Project.

During this period, Avery decided to move from Gainesville to Atlanta, which had a larger black community. Many of Avery's activist friends lived in the city and encouraged the move. These friends, however, were mostly white. Unfortunately, Avery had few contacts in black communities and activist organizations through the nation, and even fewer in Atlanta. Her white friends' connections to the black community proved crucial to Avery's growing ability to become more deeply connected to black communities and other black activists. As the project began to take shape, Avery began working to find other black women who might be interested in joining the project and the NWHN. “I didn't know enough black women around the country,”

97 Avery interview, 26.
98 Silliman, Undivided Rights, 67.
Avery noted, “but I knew white women, and so whenever they would say to me what can I do to help you, I would say do you know a black woman” who might want to get involved in the project."99 White friends and activists introduced Avery to Lillie Allen, a black activists and health educator, who became critical to the development of the NBWHP's self-help concept, and Eleanor Hinton-Hoyt, an activist who later became president of the NBWHP.100 Despite discouraging results initially, during her first year in Atlanta Avery managed to connect with twenty other black women interested in both the project and Avery's mission.

The twenty-one women in Atlanta, began conceptualizing a conference on black women's health: the first such conference in America's history. Although there had been a number of women's health conferences, none had been solely devoted to the health of black women. The group recognized the importance of such a conference, but they all acknowledged that they could begin working immediately to improve the lives of black women in Atlanta. The amount of planning, networking, and fund-raising needed to develop the conference would take years, but the planning committee had already dedicated itself to improving the lives and health status of black women. Thus, Avery and Pamela Freeman began working on various programs while the planning committee began the long, hard work of developing the conference.

What kind of programs would work best to improve the health of black women and what would the goals of these programs be? Avery and Freeman began conceptualizing a series of programs that would address “prevention methods including diet and nutrition, medical screening, exercise, and teenage pregnancy prevention” while working with national and local organizations including The Urban League, the National Council of Negro Women, and any

99 Quoted in Morgen, Into Our Own Hands, 45.
100 Avery interview, 26.
other local groups which would want to become involved in these programs. In order to address these myriad issues, Avery and Freeman began developing local self-help groups in ten cities throughout the nation. These self-help groups would be controlled by group members with the support of the NWHN and project members. Freeman emphasized the importance of member control over the groups. “We need to learn how local women see things- what works for them in their own communities,” Freeman argued. The self-help groups would allow women to work both individually and collectively to improve their health as well as the health of their families and communities. By the summer of 1983, there were more than one dozen self-help groups in Florida, Georgia, Alabama, Tennessee, Rhode Island, New Jersey, Pennsylvania, Minnesota, Michigan, and California.

Avery traveled to Gainesville in order to facilitate the first of these groups since she was comfortable with the area. Twenty-one obese women gathered with Avery to begin discussing the potential health problems associated with obesity and ways to achieve a healthy weight. According to Avery, she believed the first meeting would be easy; she would talk to the group about losing weight, the dangers of high blood pressure and diabetes, and this knowledge would inspire them to work toward a healthy weight. When Avery sat down to talk with the group, however, they revealed they already knew about weight loss programs and obesity related illnesses. Most had tried low calorie diets and Weight Watchers, they knew about their medication, and most even had blood pressure-reading machines in their home. The problem was a not a lack of knowledge. As one group member described:

I work for General Electric making batteries, and, from the stuff they

102 Ibid.
103 Morgen, Into Our Own Hands, 45.
suit me up in, I know it's killing me... My home life is not working. My old man is an alcoholic. My kids got babies. Things are not well with me. And the one thing I know I can do when I come home is cook me a pot of food and sit down in front of the TV and eat it. And you can't take that away from me until you're ready to give me something in its place.¹⁰⁴

Clearly, these women understood the dangers of obesity and the many programs which could aid in their weight loss. This knowledge, however, was not enough to aid the women in losing weight. Food provided the women in the group with emotional satisfaction, however fleeting and detrimental to their physical health. Avery began to realize black women needed to find fulfillment through self-esteem and empowerment. Empowerment was critical and, for many black women, missing in their lives. For a program to succeed in helping black women, it would have to combine knowledge with empowerment.

Avery returned to the planning committee with this new understanding of the situation for many black women and the group began brainstorming on how to provide black women with the health information they wanted in conjunction with the empowerment they needed to act on this knowledge. The committee worked together and discovered that, as black women, “we are dying inside... unless we are able to go inside of ourselves and touch and breathe fire, breathe life into ourselves... we couldn't be healthy.”¹⁰⁵ The group would have to work to bring together black women, with their variety of life experiences, to discuss why many were unhealthy and in psychological distress. Talking to each other would be critical, Avery and the committee argued,

¹⁰⁵ Ibid., 8.
because “the conspiracy of silence is killing us.”106 The various forces of racism, classism, and sexism had kept black women virtually isolated from one another, rarely discussing the ways in which these forces negatively impacted their health. Through talking with each other about their lives and their experiences, black women might break the “conspiracy of silence” and begin the hard work of transforming their lives.

Armed with this idea about what the conference needed to accomplish, the planning committee began their work on the conference. One of the first issues the group had to deal with was whether or not to include white women in the planning process. Many committee members, including Avery, wanted to include white women associated with the NWHN. Given Avery's positive relationship with white activists, and the project's relationship to the NWHN, it made sense that the committee would include white women. Other committee members, however, felt that including white women would cause further conflict. Lillie Allen, in particular, believed committee members would have to work on their own intra-racial tensions, which would be harder to accomplish with white women present.107 The women on the committee would have to address their own internalized racism, sexism, and homophobia. These problems would be difficult enough to overcome without having to grapple with inter-racial tensions. Dealing with potential conflicts between black committee members and white NWHN members could be almost overwhelming and might detract from the purpose of the conference. In order to deal with member conflicts, the planning committee opted to develop a model of collective leadership in which all decisions would be made by consensus. The committee chose this model purposely to counter a model of charismatic leadership which dominated many civil rights organizations and a

107 Silliman, Undivided Rights, 69.
number of feminist organizations. The hope was this type of leadership would allow the committee to grapple with their potential problems with each other without hurting the conference planning process.

Figuring out the theme of the conference proved to be an exciting process for committee members. The committee wanted to put together a conference that participants would enjoy attending and that would address the needs and concerns of diverse women. A major goal of the conference planners was to appeal to black women from a wide variety of class and educational backgrounds. Activist and committee member Faye Williams suggested the conference should be developed around civil rights activist Fannie Lou Hamer's famous statement: “I'm sick and tired of being sick and tired.” The committee, at Avery's urging, also adopted a tentative conference program which embraced her personal belief that black women's health needed to be handled holistically. Her own experiences with poverty and violence had taught her that health was a far broader concept than many health care professionals and previous activists had acknowledged. The committee planned workshops on family and community violence, patients' rights, funding individual health care, developing self-esteem, and alternative lifestyles. Avery's religious convictions, along with the spirituality of other members, pushed the committee to embrace a spiritual, if not precisely Christian, approach. Committee members supported non-denominational spiritual ceremonies and emphasized the importance of dance and music to individual spiritual health and development. The conference hosted a performance by the black female band, Sweet Honey in the Rock, and hosted an African cultural extravaganza.
urging black women to embrace their African roots.\textsuperscript{112} Although discussing the poor health status of black women nationwide could be a depressing experience, the committee wanted to ensure conference attendees would leave empowered and emotionally/spiritually fulfilled. More than anything, the committee wanted the conference to be a celebration of black women and their experiences. For this reason, they argued, the conference must provide health information while also feeding the souls of the attendees.

Avery and the other committee members recognized they needed clear objectives for the conference. Otherwise, it would not be nearly as effective. The planning committee outlined five objectives for the conference: “1) to educate black women about health care and health facts; 2) to present a cultural and historical perspective on health in relation to black people; 3) to teach self-care skills; 4) to bring an awareness about the public policies that impact on health access; and 5) to establish a network among black women.”\textsuperscript{113} These objectives reflected Avery's own goals in founding a Black Women's Health Project within the NWHN. Throughout her life, Avery believed she had little control over her own health care and that her lack of knowledge negatively impacted the health of her family. The Averys, had they known more about the dangers of hypertension, might have been empowered enough to demand adequate care, possibly saving Wesley's life. These objectives, Avery argued, would show black women that “the individual has, to some degree, control over factors promoting health, such as diet, lifestyle, and approach to problem solving.”\textsuperscript{114} The conference would provide black women with the knowledge about their bodies they needed, show how social, political, and historical factors have impacted their health, and begin building connections between black women, connections which had not always

\textsuperscript{112} “First National Conference,” 14.
\textsuperscript{113} Ibid.
\textsuperscript{114} Avery, “Prospectus,” 2.
been fostered by black women. For much of the history of black women's activism, class tensions prevented wealthy and impoverished black women from working together for extended periods of time. As Deborah Gray White notes, wealthy black clubwomen, while insisting they were tied to the most impoverished among them, generally looked down on their poorer sisters. Throughout much of the late nineteenth- and early twentieth-centuries, women of varied classes rarely interacted.\(^\text{115}\) Thus, inter-class organizing was rare and difficult. This situation did not change significantly as black feminists organized in the 1970s. As Kimberly Springer argues, “few [black feminist] organizations were able to effectively challenge classism internally in and externally to their organizations.”\(^\text{116}\) Poor black women in predominantly middle-class feminist groups, such as National Black Feminist Organization (NBFO) and the National Alliance of Black Feminists (NABF), consistently accused the leadership of focusing on middle-class issues. Lacking a salient critique of capitalism, working-class black women charged middle-class leadership with ignoring poor women's concerns, charges which fostered tensions between the classes.\(^\text{117}\) Conference planners, many of whom had contact with these organizations, recognized the need to overcome these tensions. In particular, Avery stressed the importance of the connections between black women. Although her relationships with white women were largely positive, she regretted her earlier lack of relationships with other black women. Connections with other black women helped Avery further develop her activism, and stressing these relationships would also aid conference attendees in furthering their own activism. Additionally, there is power in numbers, and building these relationships amongst participants might encourage them to work together to combat the affects of racism, sexism, and classism. Ultimately, through these

\(^\text{115}\) Gray White, \textit{Too Heavy a Load}, 54-55; 78-79.  
\(^\text{117}\) Ibid., 124.
objectives, the planning committee hoped to turn the attendees into empowered health care consumers.

Developing these knowledgeable and empowered health care consumers was a central goal of the conference. Achieving this goal, however, could not make a significant impact for black communities if the conference did not reflect the class, educational, and regional diversity amongst black women. The planning committee wanted to empower as many different black women as possible, especially those women who might not have economic advantages. The committee began consciously working to ensure this diversity, sending registrations to women in the Virgin Islands and Puerto Rico, and reaching out to senior citizens, deaf women, and women with physical challenges.\textsuperscript{118} The committee also decided that each member would begin organizing in her local community, encouraging black women of all stripes to find their way to Atlanta. Cognizant of the challenges working-class women would have in attending the conference, they began working to raise funds in order to provide scholarships to fund travel and lodging for poor rural and urban black women. Ultimately, as many as 25\% of women at the conference were able to attend because of these scholarship funds.\textsuperscript{119} The committee understood that it would be difficult, if not impossible, for poor women outside of Atlanta to fund a weekend-long trip, but that the conference could not be considered a success if poor women were not represented among conference attendees.

As the planning committee began sending out registration forms they were shocked by the numbers of cards which were returned. At first, Avery believed the conference would manage to pull in, at most, 200 women. However, registrations began pouring in. “I would go to the post

\textsuperscript{118} “First National Conference,” 13.

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office,” Avery recalled “and I would pick up an envelope and it would have 50 registrations in it-50 registrations. It was incredible. It was just incredible.”120 Women around the country began organizing, finding ways to bring black women from across the nation to Atlanta. Conference attendees rented buses to transport women from as far as California. Billie Jean Young, a poet and activist, “brought a bus load of people that started a bus in Mississippi and went through Georgia and then came on to Atlanta. . . we had buses there from Philadelphia, buses from Washington D.C., and buses from New York.”121 Loretta Ross, a prominent activist and feminist based in Washington D.C., organized with other activists in the anti-rape movement to travel together from the capital to Atlanta. The conference quickly became popular amongst activist circles as groups and individual activists encouraged friends and colleagues to attend. The planning committee was simply unprepared, but thrilled, by the number of women who showed up on June 24, 1983, the first day of the conference.

Approximately 2,000 women flooded Spelman College's campus in Atlanta during that summer weekend. Participants and planners alike felt deeply moved and inspired by the gathering together of mostly black women, all excited to discuss their health and health care. Many conference attendees expressed intense emotions at seeing so many black women gathered together to discuss issues important to them. One attendee described her overwhelming emotions during the conference. “I really didn't talk that much that weekend,” she recalled. “My heart was literally in my throat. To arrive on that campus and see black women of every hue, you know, blue eyes, fair skin, dark skin, no hair, dreadlocks, straight hair and permed” was wonderful and awe-inspiring.122 As many participants would note over the next few days, this large of a

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120 Avery interview, 27.
121 Ibid.
122 Quoted in Morgen, Into Our Own Hands, 45-46.
gathering of black women was unique. Few had previously had the opportunity to gather with black women of various classes, sexualities, ages, and from all parts of the country. Avery was particularly excited to see so many older and younger women working together and celebrating their relationships. “I remember taking a picture of four generations of women who were there. And people came brought their mothers and their sisters and their relatives. I had never been to a conference where people brought their family members. People just go themselves. . . It was one of those blessed things.” Loretta Ross believed “what was particularly exciting about this opening conference was it brought poor black women and middle-class women, rural and urban women in dialogue that was enriching and exciting to both.” As noted earlier, inter-class organization was often fraught with tensions. Conference planners believed, however, that health issues could bridge these class boundaries.

For many, the conference was the first time they had the opportunity to discuss life issues with other black women in an open and supportive environment. For participants, it was truly a weekend of celebration and overcoming the very real differences between the women at the conference. As Dr. Alyce Gullattee, one of the many speakers at the conference, stated, “I do not advocate a pathological preoccupation with blackness. But blackness is the one thing that melds us together for now and forever.” Celebrating black women and their activist potential became a critical part of the conference.

This celebration of black women was so central to the conference that some planning committee members believed white women should not be able to attend. Although the conference was sponsored by the NWHN, a predominantly white organization, some committee

123 Avery interview, 28-29.
124 Quoted in Silliman, Undivided Rights, 70.
members strongly believed the conference should only admit women of color. Fearing that white women might take over the conference and push their own agenda, some committee members fought to keep the space open only to women of color. Few took issue with allowing other women of color, including Latina and Native American women, to attend the conference. Avery, however, urged the committee to allow white women to attend. Although she recognized the potential conflicts between black and white attendees, she stressed the importance of coalition-building with white activists. Allowing white women to attend would also “give black female health consumers the opportunity, for once, to tell them to their face what we wanted, needed, and demanded.”

She also believed they could not, in good conscience, forbid the women who helped fund the conference from attending. It was finally decided that white women would be allowed to attend, but they would not be welcomed in all workshops. These three workshops, “Black and Female: What is the Reality?,” “Blues and the Black Woman,” and “Black Women and Self-Esteem,” were forums for black women to express their often painful experiences with racism, classism, and sexism. In these workshops, the women who attended would “share some deeply personal, often painful experiences that made up the sum of their black female-ness.” These workshops were particularly powerful for those at the conference. Avery argues that during these workshops black women began to recognize that the process of storytelling and sharing helped them overcome the conspiracy of silence. Too often black women suffered in silence, and the workshops allowed them to finally share their burden. During these workshops black women began to “understand that we have an institution of sexism” along with racism “that's going on in our lives that tends to oppress us, and that the only we can get out from under

127 Ibid.
it is to learn how to unhook” through sharing and storytelling. Attending these workshops, in particular, inspired and empowered those who attended. One conference attendee from California remembered, “I'd never been anyplace that was for black women only. I'd never been anyplace that was for women only.” The “Black and Female: What is the Reality?” workshop was so popular it had to be moved to progressively larger rooms in order to house the 500 women who showed up. Although all of the workshops were well-attended and praised by participants, “Black and Female: What is the Reality?” was wildly successful. As one woman said, “that's [the “Black and Female” workshop] what this conference has been all about!” For many at the conference, attending the “Black and Female” workshop initiated the “click” that Avery had experienced years earlier.

The “click” that many conference attendees experienced during the conference convinced many that the Black Women's Health Project, still a part of the NWHN, needed to become an independent organization. Many conference participants argued the project could not adequately help black women if it remained part of a predominantly white woman's organization. Attendees believed only an organization, devoted to sisterhood amongst black women, would be able to bring about the changes discussed at the conference. Avery and the planning committee never even imagined attendees might demand independence for the organization. As Loretta Ross recalled, Avery's decision to support an independent project was really a response to “pressure coming from the ground up. Many women at the conference were asking Avery, “what're you going to do for us, Bylyle, because we don't want to be with these white women.” In response

128 Avery interview, 29.
129 Quoted in Morgen, Into Our Own Hands, 46.
130 Silliman, Undivided Rights, 70.
132 Silliman, Undivided Rights, 70.
133 Avery interview, 31.
to this pressure, Avery decided to work toward independence. She recognized, however, that it would be complicated for the project to break away from its mother group. Soon after the conference, Avery and a few of the others in the committee began traveling through the country, forming chapters of the organization. Buoyed by the growing project, Avery decided to approach the NWHN to convince the board to support an independent Black Women's Health Project. The board met with Avery who presented a plan for a National Black Women's Health Project which would work independently but would maintain a close relationship with the NWHN. The majority of board members supported the fledgling organization, but others believed the NWHN should keep control of the project. President Sybil Shainwald, who was not present at the meeting, later told Avery that she was extremely upset she had not attended the meeting. If she had, “that project would've never left us. That was the most important thing we had, was the Black Women's Health Project.” Others board members felt the same way, arguing the project's original prospectus made no mention of eventual independence. Given the NWHN's desire to make the organization more racially diverse, granting the project its independence was seen as a step backwards. However, Avery managed to drum up enough support and the independent National Black Women's Health Project became an official organization in 1984.

The 1983 conference appeared to be the culmination of two decades of activism for Avery. After working closely with white women in predominantly white organizations, Avery had finally realized her dream to bring together black women to discuss their health care needs. However, the conference marked the beginning of a new path for Avery. Named president of the National Black Women's Health Project in 1984, Avery was in a position to develop an organization dedicated to improving the health of black women and their communities.

134 Avery interview, 30-31.
Throughout the conference planning process, Avery had become close to Lillie Allen, a health educator she had met in Atlanta. Allen had worked with Avery to develop the wildly popular “Black and Female: What is the Reality?” workshop. Avery asked Allen to begin working to develop a guiding ideology based on this workshop: self-help. Although the term had a long history in a variety of social movements, especially in the Women's Health Movement and numerous black rights movements, Avery and Allen worked to revolutionize the concept, making it responsive to the unique needs of black women. The conference at Spelman College birthed the NBWHP, but self-help would guide the organization through its first decade of work.
Chapter 2

From Internalized Oppression to Empowerment: The Development of Self-Help

“We have been raised in a continuum of oppression,” Project member Patsy White wrote in a 1990 issue of the NBWHP's newsletter Vital Signs. “We have been socialized with myths about ourselves. Some of these myths we succeeded in not acting on. Other myths we had to cave in to based on our personal priorities.” White continued, insisting “we can become confined by the pressures of these myths to the point that our own needs and desires get buried. We are left not knowing who we are, just one big reaction [to oppression].”¹ In White's thinking, black women simply reacted to oppression in order to survive. As White noted, black women did not always work to build an autonomous sense of self. There was a way to survive, and thrive, through these oppressions while building a sense of self, according to White. The solution was involvement in a program developed by the National Black Women's Health Project (NBWHP): Self-help.

Self-help as a potential guiding program and ideology for the NBWHP emerged during the planning for the first conference on black women's health issues, but it was only after the conference came to an end that conference planners and Project founders began working to adapt self-help for a national organization. The conference planners, particularly Byllye Avery and Lillie Allen, recognized the need for a guiding ideology for the burgeoning NBWHP, especially given its origins in another women's health organization. As originally planned, the conference was not the first event of a new organization; rather, it was a program of the National Women's Health Network (NWHN) and was designed with this relationship in mind. The demands of

¹ Patsy White, “Listening is Healing” Vital Signs (Summer 1990), 6-7.
attendees for a new organization deeply affected Avery who soon sought independence from the NWHN, forming the independent NBWHP, incorporated as an independent organization in 1984. Distancing themselves from the NWHN and dedicating themselves to the needs of black women became critical to Avery and Allen. If the NBWHP was going to succeed, it would need to be both independent and unique from the NWHN. Self-help became the way to build a separate and singular organization, one that pronounced its independence while also acknowledging its roots in a largely white woman's health organization.

Byllye Avery and Lillie Allen became the architects of the NBWHP due to their long histories of activism and their centrality to the planning stages of the first conference. Both women had recognized that black women lived in a “conspiracy of silence” and understood the conference's success was largely based on the fact the participants had begun breaking that conspiracy. Given the popularity and emotional power of the “Black and Female: What is the Reality?” workshop at the conference (over 1,500 women had participated throughout the conference) it appeared to be a good starting point for exploring what black women would need from the burgeoning NBWHP. Avery and Allen, the mothers of the NBWHP and its self-help program, began the hard work of developing a program and guiding ideology for the organization and looked to Allen's workshop for inspiration.

The workshop's revolutionary power did not escape the notice of Avery and Allen, so the women began working to take the bones of the workshop and build a larger program which could meet the needs of diverse women. The program they developed, self-help, would be the backbone of the organization for its first decade. Although “self-help” had a history in a number of social movements, including the women's health movement and a variety of black Liberation
and Civil Rights Movements, under Allen's guidance, self-help became something different for members of the Project. Initially, the Project forwarded a “model of mutual and self-help activism which has been successfully used by the women's health movement,” but Allen's entrance into the Project pushed it to adopt a new conception of “self-help.” Allen's involvement in a form of counseling, called re-evaluation counseling (RC), as well as her own experiences with oppression, informed the development of the “Black and Female” workshop which became so popular at that first conference. By adapting RC, a counseling theory based on analyzing psychological injuries and the affects of oppression, and borrowing heavily from both the women's health movement and other rights movements, the NBWHP developed their own version of self-help which was responsive to the unique needs of women of color, needs which were not being met in largely white women's health organizations.

As Avery had learned in her years as an activist in a variety of women's health groups and organizations, the larger women's health movement had had little to offer women of color. A movement dedicated to providing women with information about their bodies while also wresting authority from the hands of physicians appeared, on the surface, to provide a great deal to black women who suffered at higher rates from almost all diseases. Groups in the women's health movement, however, rarely understood the unique health concerns of women of color and failed to reach them in large numbers. Providing information and urging self-examination were positive goals of the movement, but without fully addressing the psychological impacts of sexism, racism, and classism on women of color, the movement would make little headway in improving the health status of black women. Self-help was about empowerment through

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information, according to most women's health organizations, but Avery, Allen, and the NBWHP recognized that information did not automatically lead to empowerment. Black women needed “something more” in order to become empowered health care consumers and activists.

Although inspired by other self-help groups and programs, the NBWHP self-help program was something different, an often amorphous project which existed to meet the needs of black women, both individually and collectively. The self-help program had a basic structure and common goals, but individual self-help groups adapted the program to meet the needs of their members. Given its nebulous nature, it can be difficult to nail down a simple description of the NBWHP's self-help program. Defining and describing the program, however, is critical in order to understand the heart of the NBWHP during its first decade, given self-help's centrality in the organization. Any analysis of the NBWHP must include a cogent discussion of self-help despite the difficulties in providing a concise definition of the ideology and program.

During the first years of the Project, the NBWHP sought to develop a program which would grapple with the psychological scars of racism and sexism while providing health information. This program shared a number of similarities with consciousness-raising groups and other women's self-help health groups but differed in its expressed goal. The first step in empowering women of color, according to the NBWHP, would be confronting internalized oppression which supported the “conspiracy of silence” the 1983 conference had begun to break down. Allen saw potential in re-evaluation counseling (RC), a relatively new counseling theory, while Avery remained committed to the self-help program developed in older women's health groups. The two women worked together to develop a new self-help group model which combined aspects of RC and women's health self-help groups. In the eyes of Project leaders, self-
help was principally a program for empowerment, a program which would help black women in facing internalized oppression and the negative sense of self which comes from housing a piece of the oppressor by helping them build of a new sense of self. Once black women began this process of becoming empowered individuals, they could grapple with the effects of racism, sexism, and classism on the health status of black Americans. While groups in the women's health movement insisted that knowledge was power, the NBWHP argued knowledge was relatively meaningless without women who are empowered to use it. This version of self-help, which stressed a wholistic understanding of women's health, would become one of the most important legacies of the NBWHP, inspiring other women of color and making the women's health movement responsive to the needs of black women.

**Self-Help in the Women's Health Movement**

As the women's health movement rose to prominence throughout the 1960s and 1970s, the myriad differences between various groups made it difficult to pinpoint a guiding program or ideology for the movement. The NWHN worked at the national level, dealing with health policies and working toward a more equitable health care system. The Boston Women's Health Book Collective (BWHBC) began publishing a series of health guides, most famously *Our Bodies, Ourselves*, and advocated for informed health consumers. Meanwhile, women in the various Feminist Women's Health Centers (FWHC) and birthing centers provided alternative well-woman care for their clients. It appeared, at the surface, that these organizations had few commonalities excepting their advocacy for women's health. A number of similarities in goals and tactics, however, revealed these groups had a great deal in common despite the obvious

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3 The NBWHP used “wholistic” to describe a health model which would look at women as a whole. They also used it interchangeably with “holistic.” Given the NBWHP’s preference for “wholistic,” I will be using this spelling instead of the traditional “holistic.”
differences between them. At the heart of these groups and organizations was a belief in the authority of women over their own bodies and the insistence that knowledge of their bodies meant power. Whether this knowledge was gained through reading women's health texts, such as *Our Bodies, Ourselves*, or through self-examination, the women's health movement sought to place the power over one's body into the hands of the individual. Inherent in these attempts to empower women was a critique of the medical profession as a sexist institution that would, at the very least, need to be reformed if not completely overthrown. Personal experiences, rather than years of institutional education, made women the experts on their bodies.

The majority of organizations in the movement lauded the efforts of women to take charge of their own health care and force the medical system to become more equitable. The tactics used to achieve these goals, often called “self-help” by the groups, differed in important ways. The term “self-help” became an organizing tool for the women's health movement despite the differences between various programs; the ability to take one's health into one's hands was enticing to many women who had felt humiliated and powerless in the gynecologist's office. Within the women's health movement, self-help was a call to women to seek out information on their bodies and health care, both through self-examination and research, in order to tap into the power they could have over their bodies and health care.

The ways in which various groups defined self-help and used it to advance their programs differed in important ways, despite underlying similarities. Individual groups' definitions of self-help depended on how these organizations were working to enact change in the medical system. In her analysis of the women's health movement, activist scholar Gena Corea split the movement
into three segments: health organizations, women's clinics/birth groups, and self-help groups. Each wing of the movement sought to empower women while affecting change in the patient/physician relationship, even though their tactics differed. For example, feminist organizations, such as the BWHBC, generally worked to educate women about their bodies while guiding them toward needed services. Additionally, some health organizations, including the NWHN, worked politically to enact change in the medical system to make it safer for and more responsive to its female patients.

Other organizations, such as women's clinics and birth groups, worked largely outside the traditional medical system to provide care for women by women. In these clinics and birthing centers, consumers (the word patient was rarely used because activists believed a patient passively received knowledge from the expert physician, while a consumer was an active participant) shared decision-making with clinic workers, most of whom were not trained physicians. Teaching while they provided care, center and clinic workers sought to empower their consumers by showing them how to treat gynecological disorders (such as yeast infections) and to view their cervixes without the aid of a physician. These clinics and centers sought to redefine the traditional patient/physician relationship by taking the physician out the equation and making the consumer and worker equals in care.

In close relation to the clinics were self-help groups. Both the clinics and the groups shared similar tactics and goals, and some of the first self-help groups were founded by the women who ran the first feminist health clinics. Each of these segments of the movement played a critical role in advancing the goals of the women's health movement. Self-help became an

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organizing tool for various groups in each section of the movement, but it was used most vocally and dramatically by activists involved in the feminist clinics and the self-help groups. The stories of these clinics and the self-help groups are critical to understanding the self-help concept for both the women's health movement and the NBWHP. Although the NBWHP would adapt some tactics of the health organizations, their self-help concept shared more with the feminist clinics and self-help groups of the larger women's health movement than the health organizations. The self-help concept as understood by these groups and clinics can be tied to a small group of women from Los Angeles who began exploring women's health and the medical system. This group, unofficially headed by Carol Downer, became critical to the development of self-help in the women's health movement.

Downer, a white, working-class mother of six, found her way into feminist activism through the National Organization for Women (NOW). She attended a meeting in Los Angeles in 1969, and quickly devoted herself to the battle to liberalize California's abortion laws. Change was too slow, Downer believed, and the legal tactics NOW advanced were not enough to change power relations in regards to abortion care and women's health. For Downer, female control over abortion care would be a critical step in insuring adequate and sensitive care for women. Who could better understand the care women needed than other women? Physicians had far too much control over women's bodies and their reproductive decisions, Downer argued, and she began putting together a group of women to confront the abortion issue from another direction. She joined with five other housewives and asserted the group was well-prepared for controlling a women's clinic. After all, between the six women they had twenty-four children “and a combined medical experience of over a hundred years” so it seemed reasonable to Downer that they would
be able to care for other women. They would need someone to teach them the abortion procedure, however, and Downer soon found a willing provider.

Downer and the others began observing the provider perform a variety of procedures. Watching him insert an IUD (a form of birth control) into a woman's uterus after an abortion proved to be a revelatory experience for Downer. As she recounted:

There she was up in the stirrups, with a speculum in, and there, voila, was a cervix. I think the reason it had such a momentous impact on me is that I was going out and doing all this public speaking and looking at [the need for abortions] so intellectually, so politically. And then to see how beautiful and simple and accessible a cervix was overwhelmed me with the significance of it. . . this is going to change everything.

Women had always been taught that their bodies were a kind of complex machine that only highly trained physicians could understand. Even though inserting an IUD, as Downer had discovered, was relatively simple, women were made to believe only years of training could prepare one for these types of procedures. Downer, who had carried six pregnancies to term and had had one illegal abortion, noted she had a great deal of experience with gynecological exams but had not questioned the authority of her physician who had privileged knowledge over her body. It occurred to Downer that she had never been able to view her own body during an exam since physicians shrouded women, quite literally, in secrecy during their examinations. Downer decided it was time to learn about her own body.

Downer took a plastic speculum from the abortion clinic and, armed with a flashlight and

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6 Ibid.
7 Ibid.
a hand mirror, learned how to view her own cervix and vagina. The experience was awe-inspiring for Downer and she understood that self-examination might be able to throw off the power imbalance between women and physicians. Inspired by the revolutionary potential she saw in self-examination, Downer attended a meeting at Everywoman's Bookstore in Los Angeles on April 7, 1971. Feminists had been meeting there for some time, discussing abortion and other health issues. The women had banded together to begin learning about abortion, health care, and reproductive rights. The group had been frustrated by their physicians and their “same kind of no help” and began to “just rap, share experiences, and maybe as a group seek out some answers on our own.”

Women in the group expressed their annoyance with how they were treated by physicians during routine examinations and treatments. The group described an average experience of a woman seeking care for a standard vaginal infection:

I've got an itch. So I've gotta call the doctor. When I call, the receptionist. . .
proceeds to make an appointment from one to two weeks hence. So I wait. . .
Finally I get to see the physician and his comment on examining me, draped in a sheet so that I couldn't watch even if I wanted to, 'Usual female infection, take the antibiotic prescription and come back in two weeks.' When I ask him if I can see what the infection looks like, the physician is appalled at the idea. 'You shouldn't worry your little head about this kind of thing. . .' So I return in 2 weeks, and maybe it's cleared and maybe it isn't. . . I again ask for specific information about the infection and by now the answer usually comes in Greek (which I am obviously not very fluent in)."

9 Ibid.
Group members began researching women's health in an effort to arm themselves with information in order to make themselves participants in their health care instead of passive recipients of a doctor's expertise. Perhaps, if they became informed participants the traditional physician/patient relationship could change and become more equitable, group members believed.

Although “book learning” was critical in understanding one's body and health, Downer encouraged observation. After all, “in order to better understand what we were talking about we had to look.”10 During the meeting, Downer inserted a speculum into her vagina and urged the group to come examine her cervix. Lorraine Rothman, a member of the group who would play a critical role in the feminist self-help groups, was “absolutely, totally amazed” when she saw Downer quickly and easily insert the speculum. Although she had children and had gone in for countless appointments with her gynecologist, she had never before seen a speculum let alone a cervix.11 Moved and inspired by Downer's actions, many of the women present gathered groups together for self-examination. According to one group's description of self-examination, “some of us were a little shy going up, all of us [were] thoroughly with it by the time we got down.”12 Excitement and interest in gynecological self-help was so immense that Downer, along with Lorraine Rothman, began a national self-help tour. Demonstrating in twenty-three cities across the country, including New York City, Wichita, and Cedar Rapids, Downer and Rothman inspired women across the country to begin their own self-help groups.

Self-examination was truly a revolution in the burgeoning women's health movement. As Sandra Morgen argues, Downer, by inserting a speculum herself, “broke two taboos-she touched

10 The West Coast Sisters, “Self-Help Clinic.”
12 The West Coast Sisters, “Self-Help Clinic.”
her own genitals and she appropriated the tools of the medical professional to reclaim knowledge about her body.”

Tools of the physician's trade, including a speculum, were seen as forbidden items in the hands of the untrained. Although, as Downer pointed out, a speculum is not a particularly complicated tool, the idea of a woman with no medical training wielding a speculum and examining her own cervix was a small rebellion against the medical system. After all, if someone with no training could examine herself and other women with little training then what use was a gynecologist for normal issues and tests? And, if learning how to examine a woman was so simple, why had they been kept ignorant? Women had had little “real” information about their bodies. In one brochure for a FWHC, the writers argued “we have gross misinformation given to us by the male medical profession who have been the sole repository of gynecological knowledge.”

Women had been kept ignorant by men, specifically physicians, and self-examination was a way to reclaim knowledge over their bodies.

Although examining medical texts was a part of self-help groups, Carol Downer argued self-examination was even more important because “even those of use who search out the information in books of anatomy have a very unrealistic and unuseful [sic] knowledge of ourselves.”

Although a vagina is a part of a woman's body, her relationship to her genitals was a complicated one defined by her lack of knowledge and contact with her own body. This disconnect was often so severe that the men in a woman's life (husbands, lovers, physicians) often knew more about their genitals. As Colette Price, an editor of the New York based quarterly

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13 Morgen, Into Our Own Hands, 22.
"Woman's World," argued “for all practical purposes, men have probably had more intimate contact with, and certainly far greater accessibility to the vagina than women ever had.” While men's genitals are external and exposed, women's are “hidden” from obvious view. Price went on to assert “we really do seem to feel that seeing is believing” in regards to body parts. Not being able to view one's vagina and cervix added to the belief that women have neither the right nor the ability to examine their reproductive organs. Self-examination turned that belief on its head.

Self-help was so popular that, according to scholar Sheryl Burt Ruzek, within a year of Downer's first self-examination, over 2,000 women had attended a self-help demonstration and self-examination had been demonstrated in Canada, Mexico, England, France, Germany, Italy, Northern Ireland, Belgium, Denmark, West Berlin, and New Zealand by 1975. Even women who sought care at the various FWHCs who never expressed interest in viewing their cervixes were often convinced by feminist self-helpers to take a look during their exams. Downer and Rothman developed a thirty minute film on self-help which they rented and/or sold to groups around the country. The burgeoning movement was becoming so popular that a newsletter, The Monthly Extract-An Irregular Periodical, became known as the “communications network of the global self-help movement,” publishing articles its editors believed were critical to self-help. The periodical's purpose, was “to fire the Revolution by which WOMEN WILL RIGHTFULLY RECLAIM OUR OWN BODIES” and became a way for self-help groups and FWHCs to communicate with each other and other interested feminists.

The self-help groups interested other feminists and women concerned with the status of


\[18\] Ruzek, Women's Health Movement, 53-54; Morgen, Into Our Own Hands, 23.
health care. In her discussion of these groups, activist scholar Gena Corea argued it was difficult to analyze the impact of the self-help groups since they often formed and dissolved quickly and without notice, and few kept documents for analysis. There are some similarities, however, between these groups. First, the groups had no formal structure and generally had no leader. Similar to feminist consciousness-raising groups, the groups had “no rules governing participation” except that the group would agree to using “good factual material” in their meetings. In general, the groups were small; Downer's group (The West Coast Sisters) argued that ten people seemed to be ideal and the group would split into two when they reached 15 members. This informality coupled with the supportive nature of the groups which encouraged a form of testimony undoubtedly attracted women to the self-help groups.

As Downer and Rothman traveled across the country teaching the self-help process to women, they also began demonstrating menstrual extraction (as discussed in chapter one) and aiding women seeking to treat their own minor disorders. Using yogurt to treat yeast infections was far easier and cheaper with fewer side-effects than the traditional prescription treatments. In fact, the majority of tests and treatments sought from gynecologists (including pap smears, pregnancy tests, and prescriptions for vaginal infections) were simple and cheap, suggesting laywomen were just as qualified as physicians. It seemed only natural to Downer that the next step for activists would be to open their own alternative, feminist health care facilities. After setting up shop at the Los Angeles Women's Center and continuing to demonstrate self-examination, Downer and Rothman worked to open a health center. In 1972, they were able to open the Los Angeles Feminist Women's Health Center (LAFWHC), the first of a series of

19 West Coast Sisters, “Self-Help Clinic.” The group doesn't define “good factual material” except to suggest the use of “standard texts” and the Birth Control Handbook put out by Montreal Women's Liberation.
20 Feminist Women's Health Centers Brochure; West Coast Sisters, “Self-Help Clinic.”
woman controlled health clinics in the United States.21

The various FWHCs throughout the country continued to sponsor self-help groups and encouraged women to begin meeting on their own to discuss various women's health issues. The groups and the FWHCs viewed their actions as explicitly political. As one self-help group, sponsored by the LAFWHC, argued, taking control of one's health through self-examination is a step on the “road to self determination.”22 This step, according to the LAFWHC, was a tangible “solution” to the problem of women's health care. In an article on self-help, Carol Downer argued “most women's liberation projects have been organized around 'problems' such as rape crisis centers, do-it-yourself divorce classes, etc., instead of around 'solutions'.”23 For these groups, especially the FWHCs, taking control over women's health was a critical step in women's liberation. Diagnosing vaginal infections, confirming pregnancy, and treating yeast infections with yogurt may not appear, on the surface, to be political acts, but the self-help groups and FWHCs took the feminist mantra “the personal is political” to a new level, insisting that personal medical issues had been used as a form of control by the patriarchal medical establishment. Physicians, feminist self-helpers argued, had used women's ignorance of their bodies to keep them in a state of subjugation. Male physicians had gone as far as to convince women that certain normal variations, such as tipped uteri, were cause for medical intervention. Activists argued women underwent unnecessary hysterectomies and mastectomies, gave birth uncomfortably (and sometimes dangerously) for the convenience of physicians and their staff.

21 Morgen, Into Our Own Hands, 8. According to Morgen, it is difficult, if not impossible, to know how many women-controlled health clinics existed in the 1970s. She lists a number of sources which put estimates of 50 clinics operating by 1976. Morgen, Into Our Own Hands, 71.

22 West Coast Sisters, “Self-Help Clinic.”

and had been “drugged, strapped, cut, ignored, enemaed, probed, shaved – all in the name of 'superior care'.”

Some activists went as far as to argue current gynecological practices had produced illness and disease in otherwise healthy women. Given this maltreatment, feminist self-helpers argued, the only solution was to bring women's health care into the hands of women. The self-help meetings were the first step toward the ultimate goal of providing women care by other women. By bringing control over the female body back into the hands of women, they were taking the first step in overthrowing a sexist system. As Downer wrote quite simply, “we want to take over women's medicine – nothing less.”

What constituted “women's medicine,” however, was going through a redefinition in the self-help groups and clinics. Through defining “normal” for women, feminist self-helpers began the process of de-medicalizing a number of women's health issues (such as well-woman pap smears and childbirth) while developing an alternative form of health knowledge based on women's observations. The self-help groups and FWHCs took the notion that the “personal is political” to heart and insisted women's personal experiences would have to be the basis of a new shift in medical practices. As historian Wendy Kline argues, the women's health movement took seriously the idea that individual women's experiences of their bodies and of the medical establishment were more important than scientific analysis. As she notes, many groups within the women's health movement insisted “knowledge and power are rooted in the biological body” and

24 Downer, “Covert Sex Discrimination.”
25 Feminist Women's Health Center, “Well Woman Health Care in Woman Controlled Clinics,” 1976. Women's Community Health Center Papers, MC 512, Box 12, Folder 1. The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute for Advanced Study, Harvard University, Cambridge, Mass. In particular, the FWHCs pointed to hormonal forms of birth control and estrogenic treatments of menopause. Both caused a number of negative side-effects including cancer and blood clots in many patients. Additionally, Downer argued the US government had failed to adequately address the spread of venereal diseases, leading women not to recognize symptoms and not seek treatment, thus leading to the worst outcomes. Finally, the FWHCS pointed to the rise in unnecessary hysterectomies and mastectomies as evidence of this trend.
that personal stories became the backbone of feminist health knowledge. Medical texts could provide information on how professional physicians viewed women's bodies, but self-examination and discussing health care experiences would be at the center of a new kind of health knowledge. In her analysis of vaginal self-examination, Michelle Murphy notes “experience, as conceived within the feminist self-help movement, provided a kind of evidence that was used to critique science, especially biomedicine, by providing a different knowledge of the world.” Inherent in feminist self-help was a critique of the notion of a women's health “expert” who was not, in fact, a woman. Since the majority of medical knowledge had been developed based on male observation of women, feminist self-help groups sought to create medical knowledge based on women's observations of their own bodies. Feminist self-helpers went as far as to refuse to diagnose women in their clinics; rather, they encouraged women to “make their own diagnosis of common body states” since a diagnosis was just a “hypothesis, a tentative conclusion based on common sense.” This would be a critical aspect of the women's health movement, feminist self-helpers argued, because women had to free themselves from the constraints the medical profession had placed on them.

What was not undergoing redefinition, however, was what types of issues (whether they were “natural” events or matters for medical intervention) were considered “women's health” concerns. Although feminist self-helpers critiqued the notion that “women are encouraged to enter the health system through their reproductive organs,” the self-help clinics and groups upheld a notion of women's health practiced, traditionally, by those specializing in obstetrics and

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28 Murphy, “Immodest Witnessing,” 118
29 Feminist Women's Health Center, “Well Woman Health Care.”
gynecology.\textsuperscript{30} The self-help groups tended to focus on issues ranging from birth control and abortion to how they were treated by their gynecologists. The F WHCs focused on treating vaginal infections, performing abortions and pap smears, and providing birth control. Although they critiqued the medical field for focusing on women's reproductive organs, feminist self-helpers generally focused on these same areas. While their treatment differed in important ways from trained gynecologists, the kind of health issues they addressed were quite similar to their purported enemies. The groups and clinics which grappled with health concerns such as diabetes, heart disease, or cancers were few. This can be tied to the self-help clinics' emphasis on prevention-oriented care versus the disease-oriented care they argued physicians generally provided.\textsuperscript{31}

Self-help groups also stressed experience as a tool for organizing around women's health issues. According to the Women’s Community Health Center, a woman-controlled health center in Cambridge, Massachusetts, women “sharing information and experiences is the basis for self-help. . . as women, we have much that we can learn from each other.”\textsuperscript{32} For the LAFWHC, relying on experiences took the groups back to a time when, they believed, women had more control over their health care. In their description of a self-help group, the LAFWHC argued:

Since grandmother's time, we have lost the closeness of sisters' experiences and helpful hands. This, along with being denied access to modern knowledge has left us without knowledgeable good preventative health care. The Self-Help concept of self-examination is based on this reintroduction of sisterly sharing

\textsuperscript{30} Ruzek, \textit{Women's Health Movement}, 11.
\textsuperscript{31} Feminist Women's Health Center, “Well Woman Health Care.”
of experiences and knowledge in a commonsense, honest manner.\textsuperscript{33}

The emphasis on “sisterly sharing of experiences” was a critical aspect of the self-help groups. Self-examination conducted alone without the aid of other women was seen as “anti-sisterhood and anti-women's liberation” because it denied those individuals the experiences and knowledge of other women. “By being a select item for one woman only, within the confines of her own four walls, and without the collective help and support of her sisters,” the LAFWHC argued in discussing private self-examination, “everyone and especially the movement looses [sic].”\textsuperscript{34}

Although personal empowerment was an important part of the self-help mission, group empowerment was the ultimate goal. If an individual woman took control of her health care experience that was wonderful, but the ultimate mission of the self-help groups and self-help clinics was to wrest women's health out of the hands of physicians and back into the collective hands of laywomen.

\textbf{Origins of the NBWHP's Self-Help Groups}

Avery's experiences in the women's health movement had shown her the power of the self-help concept within these predominantly white organizations. She had participated in self-help groups through the Gainesville Women's Health Center and Birthplace, and she supported many of the goals of the groups. Although her experiences had also shown her these organizations' priorities did not always match those of black women, Avery believed some form of a similar self-help program could help black women. Her personal research into black women's health had shown her that a copycat self-help program would not adequately address the needs of black women. Although the Gainesville Center appealed to black women interested

\textsuperscript{33} West Coast Sisters, “Self-Help Clinic.”

\textsuperscript{34} Ibid.
in abortions, self-examination and alternative birthing practices had not caught the attention of many women in the black community. Avery knew the Project's self-help program would have to be something new in order to empower black women both individually and collectively. The task of developing such a program began as Avery began developing the first conference on black women's health issues.

As the conference planning committee worked on the 1983 conference's program, Avery urged the burgeoning NBWHP to found self-help groups for black women. The conference would bring attention to the health problems of black women and would help begin the process of improving black women's health but, as Avery noted, “people needed to be able work individually, and on a daily basis” for there to be any real improvements.\(^3\) Traditional self-help groups, which provided women with information on their bodies, would arm women with the information they needed in order to make better health choices. However, this knowledge was not enough. Although the larger women's health movement stressed the power of information and knowledge, Avery insisted there needed to be a sense of empowerment behind this information or else women would not begin to make changes. Although Avery understood this quite well, she needed help in developing a self-help program which would do just that: combine empowerment with information.

Avery turned to activist Lillie Allen, a health educator and Rockefeller Fellow in Population at Morehouse School of Medicine in Atlanta, for help in developing such a program. Before Allen and Avery met in Atlanta, Allen had worked in various public housing communities in the city, working to provide young black women with birth control and health information. In

these communities, Allen developed a unique program designed to teach young black men and women to understand birth control from a broader perspective, analyzing how birth control could be used to help them achieve their life goals, not just the immediate desire to prevent unwanted pregnancies. Allen worked to help the young people to look:

at birth control from a place of what they want in their lives. I wanted them to understand how to have a life. What are the things they must have in place to assure their vision? So if you don't want to have children, are you just talking about birth control? You have to first talk about your life and how you feel about your life and having a future, and what are the elements of that?36

Through art, dance, and dialogue, Allen wanted these young people to begin learning how to voice their dreams, desires, and needs. She realized, as would Avery, that information only goes so far in empowerment. Allen herself had struggled with her ability to express and affirm herself throughout her life, especially during her undergraduate and graduate careers. At Bethune-Cookman University, an historically black college in Daytona Beach, Florida, Allen felt persecuted by her classmates because of her migrant worker background and her skin which was “too dark.” She found she had a difficult time understanding her position because she had “no analysis other than the hurt and the disappointment which were telling me you can't trust black women, you can't trust black folks.”37 Allen recognized she was internalizing a racist vision of African Americans, viewing those in her community with suspicion and distrust while also internalizing the negative feeling associated with her class and skin color. While working toward

37 Ibid., 68.
her masters in public health at the University of North Carolina at Chapel Hill, she began researching and exploring internalized racism and began the hard work of facing her own internalized oppression and how to work through it.

Allen turned toward a relatively young form of therapy, Re-evaluation Counseling (RC) for help in her commitment to understanding racism and oppression. RC, also sometimes called co-counseling, was the brainchild of Harvey Jackins, a labor organizer working in Seattle. According to Jackins, the idea of RC began as a result of his experiences in aiding labor groups resolve conflicts resulting in “accidental learning” about the human condition.38 According to Jackins, in helping a friend deal with mental health issues, he noticed the friend began recovering once he was allowed to experience physical manifestations of emotions and experiences (such as crying and laughing). Although there are some who contest the truthfulness of this story, Jackins insisted the theory developed through his work with conflicted persons.39 A group of associates began working with Jackins to develop a counseling theory based on his experiences with his friend. By 1958, Jackins and those versed in his theory began providing their services to the public. Despite the foggy origins of the psychological theory, RC became a popular, if a bit controversial, form of therapy.

In order to understand RC's influence on the NBWHP self-help concept, one must have a

38 Dennis Tourish and Pauline Irving, “Group Influence and the Psychology of Cultism within Re-Evaluation Counselling: A Critique,” Counseling Psychology Quarterly 8 (1995), 37; Katie Kauffman and Caroline New, Co-Counselling: The Theory and Practice of Re-evaluation Counselling (New York: Brunner-Routledge, 2004), 2. According to Kauffman and New, Jackins “agreed to help prevent an acquaintance, Merle, from being committed to a mental hospital. During the next few months Harvy [sic] sat with Merle and listened as he cried, shook, and laughed for hours at a time, steadily progressing from an incapacitated state to recovery well beyond any of his previous adult functioning.”

39 Jackins apparently had a close relationship with L. Ron Hubbard, founder of the Dianetics Institute which eventually evolved into Scientology. Many have commented on RC's similarity to ideas developed by Hubbard. Tourish and Irving argue “many RC assumptions... are identical to dianetic ideas developed many years earlier by Hubbard, despite the repeated insistence of Jackins and his followers on the distinctiveness of their ideas.” Tourish and Irving, “Group Influence,” 40. This chapter, however, will not wade into this debate as it played no role in the development of the NBWHP self-help concept.
basic understanding of the basic theory and practices of the counseling theory. At the heart of RC is the belief that humans are inherently rational and intelligent beings who are naturally happy and enthusiastic. Human intelligence, according to Jackins, consists of the ability to create “an endless supply of new, tailored-to-fit responses to the endless series of new situations we meet” unlike other living creatures who interact with the environment “only on the basis of rigid, preset, inherent response patterns.” While animals react to situations based solely on instinct, humans look at situations and use their intelligence to develop a response. As a person encounters a new situation, she/he will compare new information with knowledge from past experiences and construct a response based on similarities to those situations, but will develop a unique response to the new problem. Given a person's ability to respond in such a way, according to Jackins, the “natural emotional tone of a human being is zestful enjoyment of life” and the relationship between two individuals is “loving affection, communication and co-operation.” Hurting oneself or others, failing to enjoy life, or making the same mistakes consistently are not a natural part of the human condition, according to Jackins. However, human beings are often not “zestful” and do not always relate to the world in the manner Jackins describes. Something goes wrong. What happens?

According to Jackins, the answer is simple: humans get hurt. “When hurting, physically or emotionally, our flexible human intelligence stops functioning,” Jackins argues, leading to the “mis-storage” of information. While the thinking person takes in information from a new experience and stores it so he/she can use it to handle the next experience, the individual in

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distress is unable to properly store this information.\textsuperscript{42} Intelligence, then, is the ability to learn from previous experiences and apply the information to another instance. In RC theory, the information gathered during most experiences is stored as bits of information readily available for the “thinking” person to use piece by piece or all together, whichever is best for the particular situation. Mis-stored information, however, is available only in “one big tied-together chunk.”\textsuperscript{43}

Once mis-storage occurs, these experiences become “recordings” which “become compulsive patterns of behavior, feeling, and verbalizing when restimulated by later experiences which resemble them strongly enough.”\textsuperscript{44} According to Jackins, these compulsive patterns explain “all observable irrational behavior in human beings.”\textsuperscript{45} If these are the effects of mis-storage, however, then what is the “normal” or “positive” response to distressing experiences, given that all humans will become distressed throughout their lives?

Humans are equipped to deal with distressing events, Jackins argued, without mis-storing and repeating/recording. Almost immediately after a distressing experience, people instinctively attempt to rid themselves of this “bad existence residue” by “discharging” the negative emotions in the presence of other humans.\textsuperscript{46} The physical signs of this process include: “crying or sobbing (with tears), trembling with cold perspiration, laughter, angry shouting and vigorous movement with warm perspiration (tantrum), live, interested talking” and occasionally “yawning, with scratching and stretching.”\textsuperscript{47} Humans instinctively turn to others during this process and this is when things can go wrong. In discussing the discharge process, Jackins provides an example. A child is separated from his/her mother on a street for a few minutes which is a distressing

\textsuperscript{42} Jackins, \textit{Human}, 29, 33. 
\textsuperscript{43} Ibid., 38. 
\textsuperscript{44} Jackins, \textit{Guidebook}, 4. 
\textsuperscript{45} Ibid. 
\textsuperscript{46} Jackins, \textit{Human}, 78. 
\textsuperscript{47} Jackins, \textit{Guidebook}, 3.
experience. The mother returns and if she is “relaxed, aware, attentive, and undistressed” and gives her child her attention and concern but “keeps her mouth shut and does not talk, sympathize, jiggle, distract or interfered, then the damage repair process of the baby goes into action.”48 The baby will cry and will probably do so for a long time but will soon be done. The child will once again become happy, alert, and enthusiastic. According to Jackins:

the profound healing process of which the tears are the outward indications has drained the distress from the mis-stored bad experience residue and the baby's mind can now get at the information itself, perceive what actually happened and finally evaluate it, make sense of it, understand it. The mis-storage becomes converted to ordinary information, is stored correctly, becomes available to help understand later experiences with in the usual way.49

However, problems arise when a parent or caregiver is not aware and attempts to comfort or scold the child during the discharge process. Although these actions are often well-meaning, according to RC theory comforting or scolding makes problems worse and leads to life-long problems in dealing with similar situations.

The problem of human irrationality is not only a personal issue, Jackins argues, but also a societal problem. RC theory postulated that humans are naturally co-operative and highly intelligent. Thus, when conflicts arise both within and between societies, it signals some sort of dysfunction since this type of behavior contradicts human nature. Given RC’s rise during the 1960s and 1970s, commitment to liberation movements, whose existence rests on societal

48 Jackins, Human, 77. Italics in original.
49 Ibid., 78.
dysfunction, became a crucial part of the RC movement. However, RC’s commitment to grappling with oppression only came about when RC women, many of whom had been involved in feminist consciousness-raising (CR) groups, demanded the organization begin dealing with the lack of respect given to its female members. According to one account of a meeting in Seattle, a number of women who had been involved in a few CR groups spoke before the others present at the meeting and “discharged” various instances of having been hurt by men. Katie, an RCer present at the meeting, recalls it turned “into a lively and angry speak-out” against the inequities suffered by women. During this session, the women present began to make connections between RC and sexist oppression. Katie goes on to write:

For many of us, it [the meeting] was as if a light bulb had been turned on. Women who have never thought in these terms before, myself included, picked up the theme and used our turns to discharge about our hurts from sexism. We women knew something exciting and important was happening. We were like popcorn being freed from the pot! Righteous indignation and a sense of sisterhood blossomed.

This swell of anger amongst RC women was tied directly to feminist consciousness-raising groups which had become popular by the early 1970s when this incident took place.

Feminist consciousness-raising groups rose in popularity and influence in the later 1960s and 1970s in response to women’s experiences in the Civil Rights Movement and in male

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51 Kauffman and New, Co-Counselling, 73.
dominated leftist groups. The notion that “the personal is political” became the backbone of the CR groups. The term, coined by Kathie Sarachild, a civil rights organizer and radical feminist, described “the process by which women in small groups could explore the political aspects of personal life” through the sharing of life stories. According to Sarachild, women would only be able to “see the reality of their lives” when “they grasped that their problem were not theirs alone.”

The goal of the CR groups was not just to let women talk through their feelings; women were supposed to experience what feminists called “the click.” This click was “the sudden comprehension, in one powerful instant, of what sexism exactly meant, how it had colored one's own life, the way all women were in this together.” Participating in CR was supposed to be an important step toward building a kind of class consciousness amongst women which would lead to a kind of revolution against sexism. It was during feminist CR that individual women would make connections between their personal lives, the lives of other women, and the ramifications of sexism on their experiences.

The women who stood up at the Seattle RC meeting had experienced “the click” discussed so frequently in CR groups. By combining the politics of CR with the discharge process of RC, the female RCers began developing a belief that sexist oppression caused injuries and mis-storage that would have to be discharged, just like any other psychological injury. The blossoming sisterhood RC women felt upset RC men who were “either cowering guiltily or showing the tense postures of defensiveness” during the impromptu speak-out. Although the meeting ended with anger and hurt feelings on both side, the event marked a growing awareness of sexism within the RC community.

According to RCers Katie Kauffman and Caroline New, awareness of sexism was growing throughout the RC community, inspired by RC women's commitment to calling out sexist treatment. As a larger community, RCers began “to think carefully about the kinds of hurts women were reacting to” and it soon “became clear that sexism was just one example of a class of hurts that happen to people because they belong to particular groups in society.”

In response to RC women's calls to address sexism, the RC community began holding workshops in 1975 to discuss various types of oppression. Groups (including women, Jews, people of color, Catholics, gays and lesbians) met separately to discuss the role oppression played in their lives. Once the groups came together the RC community made a goal to eliminated racism, sexism, classism, and other oppressive attitudes in RC meetings and the larger community. RCers began developing their own working definition of “oppression” and began showing how RC theory could be used to respond to an oppressive society.

Given the theory's emphasis on distress recordings, RCers argued no person would submit to oppression unless a distress recording was installed when the person had been hurting. Additionally, since humans are naturally good and loving towards others, RCers argued that no person would oppress another unless they had a distress recording installed through a hurt and then “manipulated into the 'other end' of the pattern to play the role of the perpetrator of hurt or the role of the oppressor.”

Oppression acts at the individual level, according to RC, but how does oppression work at the societal level?

According to RC theory an oppressive society “will reimpose new distress daily, through classist, sexist and racist institutions. The personal is political. What RC refers to as 're-
emergence' from distress thus ultimately requires participation in movements to change society.\textsuperscript{57} Racism, sexism, and classism, according to Jackins and RC proponents, are symptoms of a society which has been collectively replaying destructive patterns. RCers believe caretakers often pass on “cultural misinformation” to their children, for example, the belief that some people are bad, unequal, or powerless, and these beliefs become reinforced by the larger society.

In discussing RC's role in black liberation, Suzanne Lipsky, an RC counselor, argues:

Racism is a form of oppression that has been systematically initiated, encouraged, and powerfully enforced by the distress patterns of individual members of the majority culture and their institutions. Black people have been the victims, the primary victims in the country, of every form of abuse, invalidation, oppression, and exploitation.\textsuperscript{58}

Institutional or societal forms of oppression are reflections of individual distress patterns which are replicated for generations until they become societal patterns.

For African Americans specifically, Lipsky describes how these distress patterns affect, and are affected by, individuals within black communities. The distress patterns “created by oppression and racism from the outside” have been re-enacted by African Americans in the only two places that have seemed “safe:” upon “members of our own group- particularly upon those over whom we have some degree of power or control, our children” and upon “ourselves through all manner of self-invalidation, self-doubt, isolation, fear, feelings of powerlessness, and despair.”\textsuperscript{59} This internalized oppression is a form of distress pattern, according to RC theory, and must be discharged in order for black Americans to take “the lead in ending all racism,

\textsuperscript{57} Tourish and Irving, “Group Influence,” 3.
\textsuperscript{59} Ibid.
oppression, and exploitation.”\textsuperscript{60} Thus, as RC theory argues, in order for black men and women to grapple with the political and social ramifications of racism and oppression, they must first be able to discharge their own internalized distress patterns.

In RC theory, in order for humans to be happy and healthy the discharge process must take place. However, as RC theory argues, few adults have been allowed to discharge throughout their lives. How, then, do adults “re-emerge” from these distress patterns and go through the discharge process that had previously been interrupted? RC seeks to rid adults of the “restrictions, inhibitions and aberrations of the accumulated distress experience recordings” through a particular form of counseling which reestablishes relationships between individuals. Conceptualized as a form of “egalitarian counselling [sic],” RC generally involves two people, one of which gives the other her/his “aware attention” and allows “the discharge and re-evaluation processes to proceed to completion.”\textsuperscript{61} In order for this discharge process to occur, however, the counselor and client must view each other as equals. In RC there is no “expert” or “authority” who conducts the counseling session. Rather, during a session, each person serves as both counselor and client. This creates a safe space for the discharge process to occur. As described before, the discharge process involves a number of physical reactions, including talking, crying, shaking, laughing, screaming, or thrashing, and the goal of the counseling process is to induce this discharge. Through a process of talking through present hurts, the session guides the client through unearthing the distress pattern causing the individual to mis-store, and the discharge process can begin. RC theory stresses, however, that talking around a

\textsuperscript{60} Lipsky, “Internalized Racism.” Some RCers claim they developed the concept of internalized oppression although many theorists and activists, especially African-American activists, would dispute this claim. The RC notion of internalized oppression developed after female RCers brought up the notion of sexism, well after the rise of the Civil Rights Movement and during the early years of the Women's Movement. Kauffman and New, \textit{Co-Counselling}, 77.

\textsuperscript{61} Tourish and Irving, “Group Participation,” 2; Jackins, \textit{Guidebook}, 4.
problem or only discussing the feeling surrounding a specific event is insufficient. In order for the process to work, the client must discharge.

Although RC theory stressed the importance of one-on-one counseling sessions, many RCers participated in larger sessions, classes, support groups, and workshops. In particular, African American and Third World RCers tended to gather in larger groups to discuss patterns of internalized racism. RCers found it was more useful for oppressed groups to meet, at least at first, separately from oppressor groups in order to discharge within the safety of common groups, free from the influence of potential oppressors.\(^{62}\) Many of these sessions, classes, groups, and workshops discussed, specifically, the distress patterns of oppression and how to discharge these hurts and move toward a different mode of living. In these larger groups, an individual would help guide the meeting and the group would begin sharing specific instances of being disrespected, discriminated against, and treated as less than other groups. To facilitate these discussions, the group leader would often begin with a question to be dealt with during that week. Such questions included: “what makes you proud of being” African American, “what are the advantages of being” white, “how were you belittled or invalidated for being” African American, “what do you wish white people understood?”\(^{63}\) Through talking with each other about personal experiences of oppression, and by facilitating the discharge process, RCers believed black men and women would be able to devote themselves to larger liberation activities.

As a theory, RC appealed to Lillie Allen on a number of levels. Its supposed commitment to liberation movements and its potential accessibility to large numbers and its affordability all helped pull Allen into the organization's folds. Allen, however, quickly discovered that her

\(^{62}\) RCers dubbed the influence of oppressors “cross-restimulation” which appears when oppressor/oppressed perform the same roles which RC is trying to undo. Jackins, Guidebook, 33.

\(^{63}\) Jackins, Guidebook, 34; Kauffman and New, Co-Counselling, 75-76.
politics and some of her priorities did not match with RC. It was difficult for her to believe that RCers were truly dedicated to black liberation and ending oppression when she was often the only black person participating in RC meetings and groups. According to Allen, RCers “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.”\textsuperscript{64} Put simply, Allen felt RCers were more interested in paying lip service to their commitment to advancing liberation movements than doing the hard work necessary to address serious inequities in RC groups and the larger American society. The organization's voiced commitment to minorities and ending oppression simply did not always translate to action on the part of RCers.

Allen also had issues with some of the aspects of RC theory, specifically in how they conceived of people moving from personal discharge to activism. There is not a clear path for the development of activism in RC, and Allen honed in on this problem. In her criticism of RC, Allen asserted it was a “one-step” process whereby people discuss and grapple with their feelings but do not move past those feelings and develop some sort of plan of action. “It is important to have your feelings,” she argued, “but the key question is what are you going to do with them? What are the actions you are going to take if you are interested in building a community of people?”\textsuperscript{65} Adopting RC wholesale would not make sense for the NBWHP, Allen realized, because the theory did not provide a format for moving past the misinformation and discharge process to a theory which could help black women develop into activists. At its most basic level, RC was a personal experience; although shared with another person (and sometimes groups), the effects of the RC process were largely personal. As Avery had noted during her first self-help

\textsuperscript{64} Quoted in Silliman, \textit{Undivided Rights}, 69.

\textsuperscript{65} Ibid.
group, black women needed to be empowered in order to become activists and advocates. RC, as such a personal process, could not equip black women with the empowerment needed in order to build a large group of activists.

Allen's experiences during her years at university and in RC groups had led her to a conclusion similar to Avery's: black women needed something more which was not being provided to them in many other groups and organizations. Although Allen saw something positive in RC theory, she had come to the conclusion that the theory needed to be adapted if it would ever be useful for the NBWHP or any other black women's group. RC could provide the frame for a new kind of empowerment process which would allow women to grapple with their internalized oppression, but Allen recognized the need to inject the lived experiences of black women into this new process. Allen began working to develop a new kind of theory or practice which would take into account the lessons she learned while dealing with her own internalized oppression. According to Allen, she understood what this kind of process would:

- look like because I had gone through it myself, learning to act outside of my oppression, building a relationship with myself, and understanding how to maintain relationship with your own people first to understand what it means to be with people not coming from a place of oppression.

RC's emphasis on disclosure and grappling with the effects of various negative personal experiences would be an important part of Allen's new process, but Allen wanted to take the framework provided by RC to a new level. She titled this new process “Black and Female: what is the Reality?” and took the workshop to Avery and the other conference committee members. This workshop would be critical to the NBWHP and their unique self-help process. As activist

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scholars Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena Gutiérrez argue, Allen “had successfully politicized RC and called it Self-Help.”67 The “Black and Female” workshop would be the first step in the development of the NBWHP's local self-help groups, the backbone of the organization for its first decade.

**The Origins of Self-Help: Black and Female, What Is the Reality?**

As the 1983 conference on black women's health issues was underway, approximately 1,500 of the roughly 1,700 conference participants attended Allen’s “Black and Female” workshop. The workshop was so popular that one session swelled to over 500 participants, the majority of whom praised the workshop and urged Allen to take the process across the country so more black women could experience what had so deeply moved conference attendees. Originally only 500 women were supposed to attend the workshop, but news spread quickly and the conference committee was overwhelmed by the large numbers of attendees trying to attend the workshop. As Allen argued after the conference, “what drew women to the project” and to the workshop “was the opportunity to work on themselves as part of the process of social change.”68

Activism as a Project member would be a dual process: work on oneself and take what you have learned and achieved out into the community. The emphasis on the personal and the individual undoubtedly attracted many conference attendees who rarely focused their energies and time to improving their own lives and health. Clearly, “Black and Female: What is the Reality?” was an overwhelming success at the conference, but what, exactly, was the process Allen developed and what sort of changes did Allen, Avery, and the NBWHP hope to bring about in black women?

According to Allen, the root of many black women's health problems was experiences of

68 Ibid., 70.
oppression and how internalizing this oppression wreaks havoc on one's mental and physical health. According to the NBWHP, health and wellness were negatively affected by racism, classism, and sexism. In her opening address at the 1983 conference on black women's health issues, Dr. June Jackson Christmas argued there were “interrelationships” between racism, poverty, health status, and access to adequate health care. Being both black and female placed extra burdens on black women. As Dr. Christmas stated:

The stresses of sexism and racism place a heavy burden on black women. Forced sterilization and experimentation, back street unsanitary abortions, mutilating or unnecessary [sic] operations and the denial of access to contraceptions, have been commonplace within the medical care system. Occupational health hazards, damaging environmental conditions. . . poor sanitation and dilapidated housing are disproportionately the lot of black women, along with malnutrition, complications of pregnancy, alcoholism, and drug abuse.  

Racism often forced black Americans into poverty, erecting road blocks to achieving economic success, which was critical to having access to quality health care. black women could also not ignore the impact of sexism on their lives, and the ways in which racism, sexism, and class issues negatively impacted their health. Along with the obvious physical health problems black women faced in a racist and sexist society, they also had to grapple with the mental health problems which arose from surviving in a world where they were told consistently they were not good enough and not meant to survive. As Avery had discovered before the first conference, many

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black women were in psychological distress, a side effect of living in American society.

Although these negative health effects from external racism and sexism were troubling, Allen recognized addressing racism and sexism in American society was an uphill battle, one which could not be won until black women were able to come together as a collective and make themselves a political, and personal, priority. Allen argued the collective power of black women had been weakened by a racist, sexist America which had convinced women of color that they were practically worthless, impacting how they treated one another. Although black women had consistently proven they were politically conscious activists through their involvement in myriad social movements throughout their history in the United States, Allen argued that, as a collective, they had “internalized all the negative things that have been said about us as black women” which led to “feelings of powerlessness and internalized oppression” as well as a fear of other black women. This sense of powerlessness often led to political apathy, at least on the surface, since many black women believed they had little ability to affect any kind of real change. As feminist activist and scholar Pauli Murray argues, systems of oppression draw their strength “from the acquiescence of [their] victims, who have accepted the dominant image of themselves and are paralyzed by a sense of helplessness.” These feelings of helplessness and powerlessness often made black women feel politically impotent, convincing them that they lacked the skills to begin the process of overcoming internalized oppression. Allen herself had felt powerless and helpless until she began the process of acting outside of her oppression, working to redefine herself in opposition to dominant forms of thinking. In order to make any real changes, Allen recognized, black women would have to learn the skills which would enable them to work

outside their oppression to become empowered individuals.

Empowering black women, then, would have to be the first step of any black women's organization, Allen argued, if it wished to enact any kind of change. Without dealing with internalized oppression, and the feelings of powerlessness oppression causes, black women would not be able to deal with their poor health status, both individually and collectively. This belief, that overcoming internalized oppression was necessary for empowerment and change, was an important tenet for many black feminists. Audre Lorde, a feminist poet and activist, argued that “the true focus of revolutionary change is never merely the oppressive situations which we seek to escape, but that piece of the oppressor which is planted deep within each of us.”

Feminist scholar Patricia Hill Collins asserted, “domination operates by seducing, pressuring, or forcing African-American women. . . to replace individual and cultural ways of knowing with the dominant group's specialized thought” which justifies “other domains of power.” Developing these individual and cultural ways of knowing while fighting through the dominant group's form of thought (a form of oppression) was a critical aspect of empowerment for many black feminists including the mothers of the NBWHP. The process of acculturation black women had been going through since their ancestors were brought to the Americas as slave labor had “destroyed our [black women's] personal integrity” by forcing them to accept the “individualistic, competitive system of America” which had destroyed their unique “ways of knowing” they had inherited from their ancestors. Thus, for the NBWHP, the first step in becoming empowered health activists would be to overcome, or at least seriously grapple with,

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internalized oppression which developed from this process of thought control.

But how does one stop internalizing their oppression and eject that piece of the oppressor which Lorde argued was inside oppressed peoples? The answer was simple, although the process itself was not: black women in the workshop would have to begin redefining themselves and their lives through a process similar to RC. Re-definition was critical to black women's activism, many feminists argued, because their identities were often sculpted by their oppressors. Defined as the “Other” in terms of race and gender, black women must constantly battle the oppressive, negative definitions mapped onto them by American society. According to Patricia Hill Collins, most black women's lives are “a series of negotiations that aim to reconcile the contradictions separating our own internally defined images of self as African-American women with our objectification as the Other.”

Defining oneself outside of this objectification requires that black women construct a new knowledge of self to replace these “controlling images.” According to a number of black feminist scholars, self-definition is essential to empowerment. Put simply, until black women were able to define themselves and build a unique personal and community identity empowerment would be nearly impossible to achieve.

Allen and the NBWHP promoted this black feminist notion of the importance of self-definition. In the NBWHP's vision statement, the Project argued that achieving wellness for black women (the ultimate goal of the organization) could not be realized without individual and group empowerment. The process of bringing about personal and “collective empowerment”

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75 Collins, Black Feminist, 99.
76 Collins argues “speaking for oneself and crafting one's own agenda is essential to empowerment.” Collins, Black Feminist, 36. Deborah King simply states “black feminism asserts self-determination as essential.” Deborah K. King, “Multiple Jeopardy, Multiple Consciousness: The Context of a Black Feminist Ideology,” Signs 14 (Autumn, 1988), 72. bell hooks, in her analysis of the feminist movement, similarly argues that black women are seen as the Other by white feminists, and that fighting against this othering is critical for black women who wish to fight sexism in coalition with white women. hooks, Feminist Theory, 12.
would necessarily involve the “RE-DEFINING AND RE-INTERPRETATION OF WHO BLACK WOMEN ARE, WERE AND CAN BECOME.” The process of re-definition would start in Allen's “Black and Female” workshop where black women could “begin defining themselves in an atmosphere of support and validation” with the aid of Allen. The full name of the workshop, “Black and Female: What is the Reality?” even suggests self-definition would be critical to the program, since a major part of the workshop would be defining the reality of being both black and female. Allen herself had started this process of self-definition before she met Avery and joined the NBWHP, so she had an idea of what such a program would look like. Drawing from her own experiences, both negative and positive, in college and the RC community, Allen began developing this workshop in order to aid black women in the process of self-definition.

In order to begin the process of re-definition, workshop attendees would have to understand how society at large defined them as black women, and how they had internalized these definitions. According to a NBWHP proposal for financial support, the workshop provided black women with an understanding of the ways “in which our culture systematically communicates mis-information regarding the inherent value and worth of certain [sic] population sub-groups” as well as “the reasons behind the propagation of such mis-information and the manner in which it is fueled” and “the effect that it has on the health of the lives and identities of individual members of targeted groups.” Echoing feminist consciousness-raising groups, the “Black and Female” workshop would provide black women with the tools to understand how

racism, sexism, and classism had played out in their lives and the effect these forms of oppression had on their physical, mental, and spiritual health.

Just as talking and sharing experiences was integral to the consciousness-raising process, it was also a critical aspect of the “Black and Female” workshops, even more so than in the traditional feminist self-help groups which stressed observation and hands-on action. Through the sharing of personal experiences, participants in the “Black and Female” workshop would analyze their “exposure to this kind of mis-information” while also learning how “to recognize and analyze the components of internalized oppression - whether sexist, racist, or classist – within themselves.” 80 In order to begin the process of re-definition, workshop participants would have to recognize and analyze the impact of false definitions and mis-information on black women. This analysis rested heavily on the ability of participants to begin talking to one another and breaking the “conspiracy of silence” Avery and Allen had discussed at length. Black women rarely spoke to one another about the realities of their lives, Allen argued, because black women had been taught to be strong, and that hiding emotions and appearing stoic was critical to this perception; talking to one another had become lost in the desire to be seen as strong and emotionally controlled. She argued,

it's time for us to start talking to each other. It's time for us to stop pretending we've got it all together. We do have it all together, but we need to turn around and ask each other how we're doing. 81

The conspiracy of silence, referenced to consistently by Avery, had created black women who appeared strong and together, but who needed to begin speaking out about their problems,

concerns, and feelings. Silence, as Allen argued, kept black women isolated from one another, denying them the opportunity to organize and utilize their collective strength and, in fact, encouraged a culture of distrust because they did not speak to each other on a deeper level. “We are a powerful group,” Allen argued, “but we can't get together because we are scared of each other.” black women had been taught to view each other with fear and disdain, internalizing society's larger racist beliefs about black women. According to Allen, in the workshop black women had to:

- explore the false definition that grew out of American society
- about black women which serves to divide and conquer us to the extent that we are unaware of these false realities. We believe them
- and we define them as being real.

This exploration was critical to the “Black and Female” workshop; through talking with each other, black women could analyze these “false realities” about themselves and each other. The process of re-defining what it means to be black and female could not occur without first understanding how society's definition of black women had negatively impacted black women both individually and collectively.

In describing the importance of this process, activist Loretta Ross, a NBWHP member and NBWHP Program Director in the late 1980s, argued that oppressions become layered on individuals as they grow up. These oppressions, which are “externally imposed,” are internalized by individuals. “It's not what they say about you,” Ross argues, “it's what you say about yourself as a result of that oppression that matters.”

82 Allen, “Black and Female,” 42.
83 Ibid.
mirrored oppressive external definitions of black womanhood. This internalization was so ingrained that even if “material conditions” changed, one's responses to oppressions did not. Thus, changing the conditions of black women's lives would not be enough to overcome internalized oppression. Rather, seriously grappling with societal definitions of black womanhood, and re-interpreting what it means to be black and female, would need to be a first step in aiding black women in overcoming internalized oppression.

Interrogating these “false realities” and definitions would be critical to forming an empowered collective of black women, Allen argued, because these internalized beliefs about the nature of black women (and black men) led to distrust between classes, negative attitudes toward lesbians and bisexuals, distrust toward women of different generations, and the need to criticize black leadership harshly and unfairly. Conference speaker Beverly Smith agreed with Allen, arguing that one of the “most insidious ways our oppressors win power over us is by persuading us to police ourselves through self-hatred, distrust of those like us and not like us.”

Overcoming these negative views of oneself and others was a critical step, according to the NBWHP, in the path toward empowerment and improved health status. Talking with each other about their experiences, and recognizing both the differences and similarities in these experiences, would allow the workshop attendees to begin the process of overcoming the internalized oppression which insisted black women were not good enough, strong enough, or worthy of love. As Allen stated during the workshop at the first conference in Atlanta, “we need to love and take complete appreciation of ourselves as well as each other.”

Love was an integral concept in the “Black and Female” workshop and the first NBWHP

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86 Allen, “Black and Female,” 42. Italicized in original.
conference. In discussing the process of empowerment, and its connection to the NBWHP, Beverly Smith, a Master of Public Health and the Director of the black Women Artists Film Series in Boston, spoke of the importance of love, especially for black women. According to Smith, learning to love oneself was of “absolute importance” in overcoming internalized oppression and becoming empowered. As Smith argues, in a similar form to Allen, black women are filled with voices telling them they are “no good or at least not good enough” and should begin moving toward a “joyful acclamation of the joy of the good of our existence, the pride that we take in our achievement and the acceptance of our weaknesses and shortcomings.” So how would black women get from self-hatred to Smith's vision? Smith argued it was a fairly simple step: black women need to “make a conscious decision that we want to love ourselves.”

Self-love was critical to empowerment, Smith argued, because it was integral to “authentic power.” Oppressors, according to Smith, rule through “brute force” rather than “authentic power” which was “loving, gentle, and strong. Not tyrannical and cruel. The other is domination, power which results in a rape of our bodies, our lives and of the planet.” Hatred of oneself and fear and loathing of those like oneself made it easier for dominating power to force individuals and groups to submit. Once oppressed individuals began the difficult process of beginning to love themselves, this love could be transferred to others in their group, leading to an empowered group which would be able to fight domination with Smith's conception of authentic power. Thus, for the NBWHP, self-love was the first step in fighting internalized oppression and seeing the beauty and power in joining with others they had previously feared and hated.

Love for one's self and one's community, then, would be critical to overcoming

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88 Ibid.
internalized oppression and working toward an empowered black female class. Building this love for self and community would be a difficult process, according to Allen, because of the negative feelings black women have historically associated with each other. This argument, that black women regarded each other with fear and hatred due to internalized racism, was one forwarded by many black feminists and womanists, and was not unique to RC theory, Allen, or Smith. Feminist scholar bell hooks described how women of color needed to “confront our absorption of white supremacist beliefs” which she argued may lead us to feel self-hate, to vent anger and rage at injustice at one another rather than at oppressive forces, to hurt and abuse one another, or to lead one ethnic group to make no effort to communicate with another.89

This distrust and hatred of self and other put barriers up between black women. Breaking down these barriers was critical, and grappling with internalized oppression would be a necessary step toward individual and group empowerment. Allen's workshop was a new potential solution to the problem of internalized racism and sexism. Allen's experiences in RC had shown her how to work through many of the issues which arose from internalized oppression. Although the terminology differed slightly, the Project's emphasis on the problem of “mis-information” echoed RC's emphasis on “mis-storage.” Thus, the “Black and Female” workshop adopted and adapted some RC techniques in order to guide black women through the process of overcoming internalized oppression and developing into empowered individuals. As discussed before, during RC sessions, oppressed groups would be asked to answer some questions about what it meant to be black, female, gay, or straight in a society which devalued these identities. In the workshop,

89 hooks, Feminist Theory, 55.
participants would be asked, “What is Good About Being Black and Female? What does it mean? What does it mean to you? I'm not talking about history, What does it mean to you to be Black and Female?” along with questions inquiring about women's self-esteem and what they might “need from Black Women.” As previously discussed, re-defining oneself as a black woman was critical to empowerment and these questions, adapted from RC, was one way of working towards this re-definition. According to Allen, once she was able to answer what it meant for her to be black and female, “I was able to make a connection with every black women in the U.S.” The notion of “sisterhood” which was so important to the majority of white feminist organizations was a concept Allen supported, to an extent, among black women. Although her life experiences were different from other black women- especially those considered middle-class or those who had lighter skin tones- there were similarities in how a racist and sexist society wounded black women. Although these psychological, emotional, spiritual, and often physical injuries manifested differently in various women, the fact remained, according to Allen, that there were injuries in all black women. These injuries were, in a manner of speaking, the ties that bound black women together despite their myriad differences.

Stressing these similarities and the importance of reaching out to other black women was a critical part of Allen's workshop. However, Allen urged attendees not to overlook the differences between women; she cautioned participants not to be misled and to recognize the differences in black women's experiences, but to also understand that all black women suffered under the weights of racism and sexism. Allen called on black women to let “nothing keep us apart” because “black women, lesbian or straight, poor or rich, light or dark are black women

Allen, “Black and Female,” 41-42.
first and we must bond around that.”

Allen envisioned an empowered collective of black women who recognized and saw value in their differences while bonding over their similarities. Fearful of the critiques of white feminists, and angry that these same feminists often erased difference in favor of sisterhood, Allen and the NBWHP wanted a sisterhood which accepted and celebrated difference.

Celebrating difference, however, did not always extend to men and white women. From the beginning, Allen stressed the importance of the workshop being open only to black women. Meeting separately from white women, although controversial among many NWHN activists who believed they had a stake in the burgeoning NBWHP and all its programs, was critical to the goal of grappling with internalized oppression and forging these new relationships. Scholars and feminist theorists have argued that “free spaces” are critical to forming political activists, especially amongst the oppressed. Scholars Sara Evans and Harry Boyte defined free spaces as “environments in which people are able to learn a new self-respect, a deeper and more assertive group identity, public skills, and values of cooperation and civic virtue. . . free spaces are settings. . . where ordinary citizens can act with dignity, independence and vision.”

In her analysis of the free space concept, sociologist Francesca Polletta argues free spaces, as understood by many scholars including Evans and Boyte, provide the opportunity to build the networks, skills, solidarity, and identity which are critical to political mobilization. These spaces, which are generally free from surveillance by the dominant group, provide for a freedom of expression generally not allowed within public spaces, a freedom which is critical to forging the ties and identities critical to movement making.

Feminist theorist and scholar Patricia Hill Collins calls these arenas “safe spaces” and argues domination, although it is a social fact, is not “hegemonic as an ideology within social spaces where black women speak freely.”⁹³ In these spaces, black women are able to speak freely with one another about the realities of their lives and can develop responses to the domination of the majority culture. Collins argues that 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 black churches), and in black women's organizations. These places only become less “safe,” however, when they are shared with those who are not black women. Although, on the surface, they appear to be exclusionary, their “overall purpose most certainly aims for a more inclusionary, just society” by fostering black women's empowerment and aiding their participation in social justice projects.⁹⁴ These safe spaces are threatening to those excluded because, as mentioned before, they are free from surveillance by powerful groups. But, perhaps more frightening to some members of the dominant group, safe spaces “foster the conditions for black women's independent self-definitions. When institutionalized, these self-definitions become foundations to politicized black feminist standpoints. . . much more is at stake here than the simple expression of voice.”⁹⁵ Although white activists often believe they are not invested in policing oppressed groups' expression and activism, their position as part of the dominant group makes the safe spaces less safe. Allen and Avery understood this and, though they had no interest in fully breaking ties with white women's groups, they insisted the NBWHP, as well as the “Black and Female” workshop, would have to be closed to all except black women. Otherwise, the safe space necessary for black women's re-definition process and burgeoning activism would

⁹³ Collins, Black Feminist, 100.
⁹⁴ Ibid., 110.
⁹⁵ Ibid., 111.
not exist.

**From “Black and Female” to Self-Help**

This process of re-definition, however, could not be completed in a one hour workshop. A lifetime of internalized oppression could not be grappled with in a short session; it would have to be an on-going process, requiring a great deal of time and effort from participants. Project members understood this and used the “Black and Female” workshop as a starting point for self-help groups throughout the U.S. and abroad. Once the self-help groups were in the hands of their members, they controlled the agenda, defining empowerment for themselves.

Defining empowerment, however, was only part of the task of self-help groups. As Avery had discovered, empowerment and knowledge went hand in hand. Black women must be empowered in order to improve their health status, the Project leaders argued, but they would also need information about their bodies to work for better health. The self-help process gave black women the space to use this knowledge to define their own visions of health and wellness. Project leaders, especially Avery, recognized that traditional notions of health (especially women's health) largely did not resonate with black women. Thus, the Project would have to provide a new vision of health and wellness for its members, a vision which took into account the unique experiences of women of color. Self-help was the foundation of the Project, and it was on this foundation that the NBWHP began working to re-define health and wellness for women of color and the larger women's health movement.
Chapter 3

Women's Health Redefined: the NBWHP and 'Wholistic' Health Care

“One of the most critical challenges facing our organization is that of improving the health quality for Black women,” NBWHP leaders argued in their first annual report published in 1989. “Statistically, we have the worst health as indicated by national data on the indices of major health problems.”1 Although the Project had been operating independently for five years by the time this report was published, disease, illness, and high mortality rates continued to plague black communities throughout the country. During its first years, working on overcoming internalized oppression and improving black women's mental health were the bedrocks of the Project, epitomized in its self-help program. As Project leaders understood, however, self-help had yet to do a great deal in improving the physical health of Project members.

The NBWHP remained committed to the idea that self-help would have to be the first step in improving the total health of women of color. Building an empowered base of black women would be necessary in improving the health of black women, the Project argued, because only empowered people would be able to make needed changes, both for themselves and their communities, to improve their health. The NBWHP had committed itself to disseminating its self-help process to large numbers of black women, and the NBWHP was more than successful at spreading self-help to black women throughout the country. The Project made the promotion of the self-help process its primary goal in 1985, leading to a major campaign to bring more women into the organization. The Project could be proud of their success; by 1989 there were 619 self-help groups and 130 chapters across twenty-two states, and 2,000 members. In 1989

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alone, the Project estimated 10,000 black women participated in a self-help group at least once.\textsuperscript{2} Within just a few short years, the NBWHP had managed to build a substantial membership base, providing black women with the tools for empowerment.

Although self-help was clearly the foundation for the Project, NBWHP leaders recognized that self-help and empowerment were not panaceas. The self-help process itself did not cure illness or disease, nor did it necessarily solve the social aspects of poor health. As founder Byllye Avery argued, self-help activities could not “secure rights and freedoms. No one can self-help their way to employment, housing, education or health care.”\textsuperscript{3} Self-help was a stop on the path to wellness, but it was not the destination. It was a tool to empower black women to improve their health, but self-help alone was not the way to achieve wellness. In order to improve black women’s health, the NBWHP would have to define both what it meant to be healthy and how the organization would work to help its members achieve wellness.

What was clear to NBWHP architects Byllye Avery and Lillie Allen was that health and wellness often encompassed a great deal of factors not often recognized by traditional health care providers. The self-help process was aiding black women in overcoming internalized oppression, the first step in improving health according to the NBWHP, and it was building an empowered membership base. However, the NBWHP needed to develop a vision of health care which took

\begin{footnotesize}
\textsuperscript{2} National Black Women's Health Project, “1990-1991 Program Objectives,” 1989, 13. Byllye Avery Papers, Box 5, unprocessed. Sophia Smith Collection, Smith College, Northampton, Mass.; National Black Women's Health Project, “1989 Accomplishments,” 1990. Black Women's Health Imperative Papers, Box 1, unprocessed. Sophia Smith Collection, Smith College, Northampton, Mass. These numbers may be underestimates. Self-help groups probably formed and disbanded without the NBWHP’s knowledge. Most self-help groups sent in status reports to the Project, but this was not always the case. Additionally, the groups often had a core of regular members, but there is no way to tell how many women showed up for only a meeting or two. These numbers are different from membership numbers, which included women who paid dues to the NWHP. By 1989, the NBWHP listed 2,000 members.

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into account the unique experiences of women of color. Avery's husband's death, her experiences at the Gainesville Women's Health Center and Birthplace, and her time at the National Women's Health Network had all guided her toward recognizing the myriad forces affecting individual and community health. Lillie Allen's own path often mirrored Avery's; her educational history, her work with birth control and young black men and women, and her time involved with Re-evaluation Counseling showed her that health was intimately connected to one's race, gender, and economic position. Most health providers, as Avery and Allen noted, did not take into account the social, spiritual, and mental aspects of health. Rather, most physicians in the medical system saw health as purely biological, housed inside the human body.

This was the major issue with the medical system, Allen and Avery argued. It did not take into account the complicated connections between health and social and economic factors. And, as the NBWHP argued, black women were not faring well under America's medical model. The Project could point to the dismal health statistics of black women and argue, with a great deal of confidence, that black communities were in a health care crisis. High maternal and infant mortality rates, lower life expectancies, and higher disease rates all indicated that African Americans were not benefiting from the medical system as much as their white counterparts. Black women in particular suffered from high disease and death rates, especially in comparison to white women. Unless there were major changes, the Project argued, the health crisis would only grow in black communities.

Part of the Project's answer to this crisis was to re-define women's health for Project members, their families, and their communities. The Project turned to a variety of critics of biomedicine (the dominant medical framework in the U.S.), especially the women's health movement and the holistic health movement, for inspiration. Adapting the women's health movement critique of biomedicine's reductionist tendencies and professional authority with the holistic health movement's conception of holism, the Project conceptualized women's health in a new way, taking into account the ways in social and economic issues impacted the mental, spiritual, and physical well-being of black women. Health, as the NBWHP defined it, was not merely the absence of disease; rather, health was the promotion of wellness in all areas for black women. The self-help process would empower black women to make better health decisions in their own lives, but it would also empower them to work toward social and economic changes needed to improve the health status of their families and communities. According to the Project, black women needed a wholistic vision of health, one which took into account all aspects of a woman's life and health (physical, mental, and spiritual). Only when health was approached wholistically, the NBWHP argued, would there be real changes in the lives of black women and their communities.5

Throughout its first decade of operation, the Project launched a number of programs, all of which were dedicated to their wholistic vision of health. However, no other program more fully realized this vision than the Center for Black Women's Wellness (CBWW), a center opened

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5 According to historian James Whorton, “holistic” and “wholistic” were basically synonymous by the 1970s, the peak of the holistic health movement. However, as the holistic movement began to incorporate alternative medicine into its program, wholistic fell out of favor. I will be using wholistic to describe the Project for two reasons. First, Project leaders consciously used “wholistic” to describe their program, and because, as Whorton points out, wholistic refers to an approach which takes into account the whole person, while holistic is a much broader term. James C. Whorton, Nature Cures: The History of Alternative Medicine in America (Oxford: Oxford University Press, 2008), 248.
by the NBWHP in Atlanta in 1988. As this chapter will show, an examination of this specific program reveals the ways in which self-help and wholistic health worked on the practical level. The CBWW helped empower its clients to make changes in their lives and their communities through the self-help process, and the Center provided a comprehensive wellness program which worked to improve the mental, physical, and spiritual health of its clients. As one of its most enduring programs, the CBWW is critical to understanding the impact the Project's wholistic vision of health had on its clients and their communities. Self-help was one of the most important legacies of the NBWHP, but without a wholistic vision of health, self-help could only go so far in improving the health of women of color. Through a re-definition of women's health, the NBWHP worked to make a real difference in the health and well-being of black women, their families, and their communities throughout the country.

**Defining Health**

In its efforts to re-define health for its members and their communities, the NBWHP was responding to, and shaping, a larger movement critical of traditional ways of health and healing. Medicine, which had “enjoyed unprecedented authority and power in post-World War II America,” came under attack during the various social movements of the 1960s and 70s. As historian Wendy Kline notes, confidence in medicine began to wane during this period of questioning and protest, as the medical field found itself besieged by outsiders. These laymen and women emphasized the importance of patient rights, criticized physicians' approach to treatment, and brought to light the abuses the medical system heaped on patients, women and people of color in particular. Instead of a trusted friend, the physician had become a potential

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enemy, asserting his authority over his patient and her body, often without her consent or understanding.

In particular, critics of the health system attacked the health model used by physicians. Traditional health care providers and researchers approached health from a biomedical perspective. According to activist and scholar Sheryl Burt Ruzek, in this type of model researchers and physicians are mostly concerned with the biological sources of disease and illness. Their focus is mainly on organ systems, cells, genes, and how disease affects these areas in negative ways. In doing so, according to Ruzek, the biomedical model divorces women's bodies from the context of their daily lives. When physicians examine their patients, the “social, psychological, and spiritual dimensions are rarely considered as essential areas for intervention for a somatic problem.” Physicians who approach their practice from this perspective generally treat the symptoms and seek a cure for specific illnesses; they rarely examine their patients' social circumstances in order to better understand how outside forces impact their health and wellness.

Additionally, biomedicine tends to be reductionist in its attempts to cure disease and illness. Reductionism, as it applies to the medical field, can be difficult to define, given how its meaning changes in different contexts. Historians Christopher Lawrence and George Weisz boil the concept down to three interrelated definitions. First, reductionism tends to identify a single cause for illness or disease, such as a virus or bacterium. Although an illness or disease may look complex to laypeople, the physician sees “complex disease phenomena” as being “ultimately

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derived from one or a few primary events such as contact with a pathogenic agent.” 9 This means that a disease or illness “can be corrected or ameliorated with proper diagnosis and reparative techniques” usually consisting of “a chemical or biological agent specifically suited to attack and rend harmless the germ or biological malfunction that caused the disease.” 10 This, of course, requires that researchers and physicians continually work to find cures to diseases; the ultimate goal is to rid the body of illness, not to simply reduce symptoms or help patients live in harmony with their sick/ill body.

Additionally, reductionism refers to the medical field's tendency to focus on specific organ systems as the location of disease. According to Guttmacher, “the biomedical model compares the body to a machine, made up of various organ systems, sub-systems, and component parts. Disease manifests itself as a malfunction in a specific area.” 11 Thus, like a mechanic, the physician repairs the “broken” piece of machine. Although all the parts of the machine/body work together, the assumption is that the broken part is still a separate entity, which can be fixed without consulting or examining other part of the machine. The tendency to view the body in this way has also led to the “fragmentation of the medical profession into highly specialized, disconnected, and narrowly focused groups.” 12 Physicians specialize in an organ system, a disease, or a section of the body, becoming “experts.” As Guttmacher notes, “conceptualizing the body as a highly sophisticated machine encourages the physician to view himself, in part, like an engineer with the ability and training to handle specialized information

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10 Ibid., 16.
11 Ibid.

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and technology,” technology that could not be used effectively by those without medical training.13

Thus, in the biomedical model, patients must cooperate with their physicians, agreeing to the course of treatment recommended. Since the physicians are seen as experts on the human body, not complying with directions leads to negative outcomes. This faith in the power of the expert, and the reliance on modern medical technology for diagnoses and treatment “fosters a hierarchical division of labor in medicine, much of which must take place within hospitals of research centers.”14 This leaves little room for patients to empower themselves to make informed decisions about their own health care. In the biomedical framework, the patient's job is to cooperate with and follow directions from her physician.

This cooperation with the physician's recommendation extends outside the clinic or hospital. Physicians expect that their job is to treat and manage illnesses. At the same time, they expect their patients to follow their recommendations on various prevention activities. For physicians, the individual is responsible “for personal health practices such as diet, exercise, and avoiding tobacco, which reduce the risk of disease.”15 This places the responsibility for one's health on the shoulders of individual patients; physicians fix the machine when it is broken, but it is the job of the patient to try and keep the machine from breaking down.16 This emphasis assumes that chronic diseases can be prevented as long as individuals follow a healthy lifestyle.

Although physicians recognize that not all illnesses can be prevented by following their recommendations for disease prevention, there is an assumption that wellness is the normal state

14 Ibid., 16-17.
16 Sheryl Burt Ruzek, “Women, Personal Health Behavior, and Health Promotion,” in Women's Health: Complexities and Differences, ed. Sheryl Burt Ruzek, Virginia L. Olesen, and Adele E. Clarke (Columbus, OH: Ohio State University Press, 1997), 118.
of the human body. Since health is the absence of disease, as long as patients live in sanitary conditions, exercise regularly, and have good nutrition and sleeping habits, the assumption is that people are relatively healthy. However, as Ruzek argues, “where health comes from, or what is to be done if women do not have health, remains invisible at best or gets glossed over or denied” by most physicians in the biomedical model. 17 The biomedical approach overlooks societal roadblocks to good health (such as access to adequate housing, employment, and insurance) in favor of a model which stresses the naturalness of wellness, and the importance of disease treatment when the body is exposed to some kind of illness.

Given biomedicine's reductionist tendencies, it is logical that physicians often defined “women's health” by the very organs that, generally, defined women, their reproductive organs. The doctors most associated with women, obstetricians and gynecologists, both specialize in women's reproductive organs, albeit at different stages of their reproductive lives. Although the definition of women's health began expanding slightly throughout the 1970s and 1980s, by 1991 the U.S. Public Health Service still had a biomedical definition of women's health. According to the organization,

women's health is devoted to the preservation of wellness and prevention of illness in women, and includes screening, diagnosis and management of conditions which are unique to women, are more common in women, are more serious in women [and] have manifestations, risk factors or interventions which are different in women.18

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18 Quoted in Ruzek, “Social,” 16.
This conception of women's health matches, quite well, the traditional biomedical notion of health, with its emphasis on screening and diagnosis of disease, as well as its emphasis on the preservation of wellness.

Biomedicine's predominance, however, was not unquestioned. One of the most critical groups of the biomedical model and its predominance in the American medical system were women. As discussed in the previous chapter, women involved in the women's health movement denounced the notion of male medical expertise on women's bodies, and physician authority in women's health care. Activists in the women's health movement worked to wrest control of women's health care out of the hands of professional physicians, arguing that they, as women, understood their own bodies better than men despite their lack of professional training. Women's health activists began disseminating health information to women, through books liked the Boston Women's Health Book Collective's *Our Bodies, Ourselves* (1971), and provided gynecological and birthing care through independent women's health and birthing centers.

Activists' critiques of biomedicine extended past physician authority, however. Health feminists fought against reductionism in the health system, especially in regards to women. According to health feminists, women were “encouraged to enter the health system through their reproductive organs,” causing physicians to view women as simply sex objects and reproductive organs. Although both men and women suffered due to reductionism, the tendency to equate women's health with their reproductive organs was particularly troubling to women's health activists. As activist and scholar Helen Marieskind argued,

we would think it very humorous to have men entering the health system through their penises, reproductive systems, and urologists;

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why do we not find it equally ludicrous that women's health care
is principally organized around her uterus and her reproductive
potential?20

This was an important problem with the medical system, health feminists argued; women's health
care was largely organized around their gynecological care. For many women, the only physician
they saw on a regular basis was their gynecologist.21 Health care for women, then, revolved
almost completely around their reproductive organs, adding to the equation of women's health
with their sex organs.

The trouble with gynecology being women's primary entrance into the health system,
activists argued, was that, as a specialty based on sexual differences, it had the “power to define
women.” Many health feminist distrusted male doctors who were able, because of their authority
and assumed expertise, to claim sex stereotypes were real and supported by medical science.
Ruzek points out that many health feminists believed obstetrics and gynecology were “a
devastating form of sexual politics, putting men's interests ahead of women's health.”22 Although
biomedicine assumes that physicians only treat illness and disease, women's health activists
noted that the politics of sexism made it difficult for male physicians simply to treat illness
objectively and not use medicine to further the power of patriarchy.

Additionally, some health feminists specifically attacked the the tendency of physicians to
view the human body as a type of machine. In *Our Bodies, Ourselves*, members of the Boston
Women's Health Book Collective (BWHBC) criticized the medical system for the way it treated
women as machines to be repaired. They argued, “the emphasis is on treatment of the symptom,

21 Ibid.
112; Ruzek, “Social,” 12.
isolated both from the rest of the mind and body and from the social context of illness.” The authors went on to describe the image of the “heroic” and “glamorous” doctor surrounded by modern technology, saving lives. The supporting ideas supporting this image of medicine were that most diseases are exclusively caused by germs, viruses and bacteria-specific, identifiable agents—and that the main problem of health care is to combat the enemy microbe with chemicals, or to repair damage done to parts of the body, which is conceived of as a machine.²³

Approaching medicine in this way distanced the physician from his patient, allowing him to view her as an impersonal machine, not as a whole person. In fact, the BWHBC speculated that the use of cadavers in medical schools, a medical students first contact with a human body, may add to this tendency.²⁴ Health activists wanted women to be treated as human beings worthy of respect when they sought medical care, not as mindless machines needing to be repaired by the expert mechanic.

Despite these arguments against reductionism and the medical system's equation of women's health with their reproductive organs, women's health activists often replicated this thinking in their own alternative health clinics. As discussed in chapter two, health feminists found a variety of ways to try and improve medical care for women. They provided health information to laywomen, lobbied the government on behalf of female patients, and founded alternative health and birthing centers. These feminist health centers provided well-woman gynecological care, including pap smears and birth control, urged self-examination, and

²⁴ Ibid., 339.
performed abortions when possible. While critiquing the medical field for their reductionist tendencies, health feminists tended to associate women's health with their reproductive organs. The kinds of health issues they addressed were quite similar to their purported enemies. The groups and clinics which grappled with health concerns such as diabetes, heart disease, or cancers were few. Even the health texts published for women, such as *Our Bodies, Ourselves*, focused on traditional women's health issues like STDs, childbirth, birth control, and sexuality. Although health feminists expanded the definition of women's health to include sexual violence and some basic preventative measures, they had yet to move completely past a similar level of reductionism.

The medical system's emphasis on disease and illness was also an issue, some health feminists argued, because it meant the health system would have to rely “mainly on haphazardly distributed, crisis-oriented, expensive, hospital-based facilities for dispensing many health services.” The for-profit medical system relied on expensive, often unnecessary, treatments, and valued the physician and his/her money making abilities above all. For many health feminists, the medical system too heavily stressed disease *treatment* rather than disease *prevention*, because prevention took money out of the pockets of the health system. Teaching women the importance of exercise, good nutrition, birth control, pap smears, breast exam, and healthy living habits would help keep them out of the physicians' office, making them feel better in the process.

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26 For example, in the second edition of *Our Bodies, Ourselves* (1976), 12 of 18 chapters focus exclusively on traditional women's health concerns. Many of the other six chapters examine related areas such as homosexuality and sexual violence. One chapter briefly discusses diet and exercise, but the bulk of the text focuses on sexuality and women's reproductive organs.


Feminist Women's Health Centers provided an alternative for women which provided low-cost preventative medical care from other laywomen.

Although women were some of the most vocal and visible critics of the biomedical health system, they were certainly not its only critics. The medical system of the 1970s also faced a “holistic health explosion.” Laypeople of all races and genders, along with a minority of medical professionals, began to criticize the medical system's emphasis on individual organ systems and its vision of health as simply the absence of disease. Holism was not a new concept in the 1970s; the term was coined by South African philosopher Jan Smuts in 1926. Originally referring to the tendency of biologists to reduce animals to biological machines, the concept picked up steam in the 1970s as more and more Americans began criticizing the exploitative medical system. A health system which appeared to offer an alternative to traditional medicine proved to be attractive to those who felt oppressed or neglected by biomedicine and other health movements.

Holistic health is an amorphous concept which brings together a wide variety of ideas and practices. It can refer to alternative medicine, such as acupuncture and herbal remedies, and also brings to mind the holistic health movement's underlying vision of health. This conception of health is best summed up by the American Holistic Medicine Association (AHMA), founded in 1978 by 225 practicing physicians. According to the AHMA, the organization supported a

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31 According to Charles Rosenberg, defining holism is particularly difficult because “twentieth-century medical holism has to be understood primarily in terms of what it was not.” He goes on to argue that there are, in fact, four holisms: historical, organismic, ecological, and worldview. At any one point, a physician or organization could advocate for any of these definitions of holism. Charles Rosenberg, *Our Present Complaint: American Medicine, Then and Now* (Baltimore: Johns Hopkins University Press, 2007), 140-142. For the purposes of this chapter, I will not be breaking holism down into these four discrete categories as advocates of holism during this period often adopted all four definitions.
“concept of medicine of the whole person which emphasizes integration of body, mind, and spirit with the environment.”

According to the holistic model, one must consider all dimensions of a person and his/her surroundings in order to understand his/her state of health. The effects of a person's physical environment, including (but not limited to) air pollution, climate change, poor housing, lack of clean water, is taken into consideration by the holistic practitioner. Additionally, holism can take into consideration a person's “social environment” including the effects “poverty, various forms of behavior deemed unhealthy, the political system, even Western civilization itself” have on a person's well-being. In essence, holism argues a person's relationship to his/her physical and social environments is as important to healing as examining physical symptoms.

Since the holistic model views the person's health in this way, it also does not necessarily support the idea that disease is caused by a simple virus or bacteria. Rather, it is “viewed as an indicator of disharmony between the individual and his/her environment or a disintegration of the essential dimensions on the individual.” Holism negates the notion of a separation between the mental and physical. All parts of the body and mind are intricately interconnected; the sum of a person was greater than his/her parts. Thus, sickness was regarded by holistic practitioners as “a general disorder of the body even if disease can be classified in terms of, say, local lesions or external etiological agents.” There may be a specific pathogen responsible for a person's symptoms, but there was more to illness in the holistic model. There was some imbalance in their body, mind, or spirit which prevented a person from feeling fully connected to all parts of herself and her surroundings. Thus, for holistic practitioners, aiding their patients in becoming whole was healing them. Ridding the body of a specific pathogen was

32 Quoted in Whorton, Nature Cures, 255.
33 Lawrence and Weisz, “Medical Holism,” 3.
35 Lawrence and Weisz, “Medical Holism,” 2.
curing the illness, but it did not necessarily heal the person. “One could cure without healing,” historian James Whorton argues, “as well as heal without curing.”\footnote{Whorton, \textit{Nature Cures}, 250.} Healing was the true goal of holistic practitioners. Ultimately, health and could not be achieved until the physical, psychological, and spiritual dimensions of the individual were integrated completely. Thus, health was the wholeness of patients, not simply the absence of disease.

The holistic practitioner was there to aid the in the healing process, not necessarily to control it. While in the biomedical model the physician is the ultimate authority on the body, holistic practitioners emphasized the importance, and power, of the individual patient. The holistic physician's job was to teach his/her patient how to manage illness and achieve wellness. After all, as one holistic health handbook stressed, the primary function of the holistic practitioner was to aid the “search for the universal healer within us all.”\footnote{Quoted in Whorton, \textit{Nature Cures}, 250.} Indeed, holistic health stressed the responsibility of the individual patient above almost all else. Although holism notes that social and physical factors may impact a person's well-being, it also places the burden of grappling with these problems on the individual. In fact, it “reinforces the medical system's already strong tendency to deal with disorders chiefly at the personal level and largely to the exclusion of attacking other levels, such as economic or social organization.”\footnote{Guttmacher, “Whole in Body,” 16.} The individual is responsible for achieving wellness, and does so through a variety of activities such as exercise, proper nutrition, and stress management.

\textbf{The Status of Black Women's Health}

Despite the attempts by all of these groups to improve the health of all Americans, members of the NBWHP could point to the status of black women's health to show that none of
these groups adequately addressed the unique health problems of women of color. In a period when strides were being made in the health sciences, leading to vast improvements in health for white Americans, black women saw their own health statistics stagnate or, in some cases, grow worse. Black Americans became ill at younger ages, stayed sicker longer, and died younger and more often than white Americans. The Project could reasonably argue that there was a health care crisis in black communities across the country, a crisis which necessitated a new vision of health and wellness.

In particular, the NBWHP could point to the health statistics published by the Department of Health and Human Services (DHHS), which showed a consistent gap between the health status of white and minority Americans. Periodically, the DHHS publishes a kind of report card on the health of Americans. In 1983, The DHHS published its annual report showing, yet again, disparities between the health status of white and minority Americans. Spurred by pressure from various minority groups and her own horror at the statistics, Secretary of the DHHS Margaret Heckler established a Task Force on Black and Minority Health, charging them with analyzing these health disparities and making recommendations to improve minority health. The Task Force published their findings in 1985 in one of the first comprehensive reports on the health status of minority men and women, especially African American and Hispanic Americans.

As the Task Force noted, since 1900 the health status of all Americans had improved in a variety of ways. Improved technology, leaps in health knowledge, and increased access to health care contributed to a rise in American life-expectancy throughout the 20th century. In 1900, the average life expectancy for an American was 47.3 years. By 1983, this number had risen to 74.7

years, an impressive rise in just a few generations. In part, this rise in life expectancy could be attributed to a decrease in fatalities from infectious diseases such as pneumonia, diphtheria, tuberculosis, influenza, and gastrointestinal infections, the leading causes of death in 1900.\textsuperscript{40} By 1984, the leading causes of death included heart disease/stroke, cancer, accidents, chronic pulmonary conditions, diabetes, suicide, chronic liver disease, and pneumonia/influenza.\textsuperscript{41} In essence, the primary causes of death had shifted from an obvious pathogenic cause to more complicated diseases with a variety of causes including, but not limited to, genetics, environmental causes, and unhealthful behaviors. Thus, while life expectancies were rising throughout the United States, the causes of death were also undergoing a major change.

Although it appears that life expectancies were rising for all Americans during this period, these statistics are a bit misleading. Although life expectancy rose for all Americans, there was still a significant gap between white and minority statistics. White life expectancy was 75.2 years in 1983 while black Americans lagged behind at 69.6 years, the expectancy white enjoyed in the 1950s. In essence, African Americans suffered a thirty year lag behind white Americans. Women, both black and white, had higher life expectancies than white men, but black women's life expectancy lagged roughly five years behind white women.\textsuperscript{42} The ultimate health statistic, life expectancy at birth, showed a significant and constant difference gap between the health of white and minority Americans.

Although life expectancy effectively summarizes the overall differences in health and wellness between blacks and non-minorities, the Task Force also analyzed the number of excess deaths in order to show the startling differences in black and white morbidity and mortality. For

\textsuperscript{40} Heckler, \textit{Report}, 1; 64.  
\textsuperscript{42} Heckler, \textit{Report}, 2; 64.
the Task Force, “excess deaths” refers to “the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the White population.”

African Americans had a particularly high number of excess deaths, especially for black men and women under the age of seventy. Between 1979 and 1981, 42.3 percent of these deaths were considered excess deaths. The Task Force further broke down these deaths into two groups, ages 45 to 69 and ages 25 to 44, in order to figure out the causes of these excess deaths.

For black men and women between forty five and sixty nine, the majority of deaths were due to cancer, heart disease, stroke, diabetes, and cirrhosis, some of the most common causes of death throughout the U.S. The statistics make clear, however, that the death rates of all these illnesses were significantly higher for black women than their non-minority counterparts. Black women's death rates for heart disease, stroke, and cancer were nearly two times more than white women. Deaths from cirrhosis and diabetes were more than two times higher. Thus, although the causes of death were similar between white and black women in this age group, the chances of dying from these disorders was significantly higher amongst black women.

For black women under forty five, the two leading causes of excess deaths were homicide and infant mortality. Homicide accounted for fourteen percent of black women's excess deaths under the age of forty-five. The age adjusted homicide rate was more than four times higher when compared to white women's homicide rate. The infant mortality rate was twice that of white women, at a rate of 2,123.7 per 100,000 deaths. When economic class is taken into

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43 Heckler, Report, 63.
44 Ibid. 70.
45 The Task Force measure the death rate from these diseases per 100,000. For heart disease, the death rate for black women was 1.5 times higher/ stroke, 1.8; cancer, 1.2; cirrhosis, 2.1; diabetes, 2.5. Heckler, Report, 67.
46 Ibid., 74; 67.
account in these statistics, the gap between white and black infant mortality rates become even more troubling. For example, in Oakland, California, the infant mortality rate in affluent white communities was three per one thousand versus twenty-one per one thousand in poor black communities.\(^47\) Thus, although the infant mortality rate appears to be twice as high amongst African Americans, the situation becomes more dire when class is taken into consideration. In some cities, such as Oakland, infant mortality rates can jump by almost 700 percent.

Although mortality rates reveal a great deal about the health disparities between African Americans and Caucasians, morbidity (or illness) rates also suggest a wide gap between white and black Americans in their health/health care. In particular, morbidity data showed that black women suffered at significantly higher rates from hypertension, diabetes, and anemia. The hypertension rates received significant coverage from the Task Force since hypertension has serious health consequences if left untreated. It is the leading cause of kidney failure and hypertension-related end-stage renal disease in Blacks and is a major concomitant of heat disease and stroke. Hypertension itself accounts for more than 5 percent of the excess deaths in Blacks.\(^48\)

As the Task Force discovered, forty three percent of black women suffered from hypertension. These rates were much higher than white women. Black women between twenty five and forty four suffered from hypertension at rates 2.6 times greater than white women of the same age. The prevalence rate jumps to eighty five percent when comparing black and white women between between forty five and sixty four. As the Task Force notes, these statistics on


\(^48\) Heckler, *Report*, 74.
hypertension “clearly show the health disparities in Blacks surfacing early in life,” causing a life
time of health problems which contribute to higher instances of mortality at younger ages.49

What accounted for these disparities? Although the Task Force was principally concerned
with exposing health disparities between minorities and white Americans, they did come to some
conclusions about the reasons behind them. In examining cancer rates, the Task Force found that
incidence rates of many cancers, such as cervical cancer, were higher among black women.
Additionally, these rates grew for black women as they dropped for white women. Along with
increased incidence rates, black women had lower survival rates of most cancers.50 Although
some physicians and researchers suggested biological differences may account for these
disparities, the Task Force argued social and environmental factors played a far more important
role. After all, they found that survival rates were far closer when adjustments were made for
socioeconomic status, suggesting the causes of increased mortality were not biological or
genetic. According to the Task Force, contributing factors to high cancer mortality amongst black
women included” lower socioeconomic status, later stage at diagnosis, delay in detection and
treatment, treatment differences, and biologic factors such as immune competence and response,
histologic patterns of tumors, and nutritional status.”51 Although there were some biological
factors involved, such as nutrition and immune deficiencies, these were not, generally, genetic
factors. As the Task Force itself noted, many of these serious health issues were related to social,
environmental, and economic factors.

The NBWHP made similar connections between health problems and non-biological

49 Heckler, Report, 75.
50 Black women's cervical cancer incidence rates were 2.5 times higher than white women. Additionally, white
women saw a 20% decrease in cervical cancer deaths between 1973 and 1981, while black women saw a 27%
increase. The breast cancer survival rate was 63% for black women versus a 75% survival rate for white women.
Heckler, Report, 92, 94.
51 Ibid., 94.
factors. In particular, the Project emphasized statistics which showed the negative impact poverty had on black Americans' health status. For black women and their underage children, the health effects of poverty were particularly telling. According to the Project, seventy one percent of female-headed households living under the poverty line were headed by black women, leading to lack of insurance and access to medical care. In fact, twelve percent of African Americans under sixty five had no insurance coverage, while twenty three percent of black children had no insurance.\(^5\)\(^2\) Lack of insurance meant that black women were largely not able to regularly see a physician, get regular exams and tests, and often waited longer to get treated for serious illnesses. As noted before, under the biomedical model early detection and treatment are key for positive results. Without insurance, the Project understood, black women would not be able to afford health care and would be overlooked by the biomedical system.

Lack of insurance and poverty had far-reaching consequences even for those who did not suffer from chronic or acute illnesses. For example, the Project emphasized the long-reaching consequences of teenage pregnancy. Many black teenagers waited more than a year after initiating sexual intercourse to utilize prescription forms of birth control, some of the most effective forms, due to lack of access and prohibitive costs. Teenage pregnancy rates in black communities were alarmingly high, due both to lack of access to birth control and a misunderstanding of their chances of conceiving. In 1981 alone, 37% of all black babies were born to teenage mothers, twice as high as in white communities, and nearly eighty percent of these pregnancies were not planned. Becoming pregnant at a younger age had both health and socioeconomic consequences. Teenage mothers and their babies faced higher infant and maternal

mortality rates, and their chances of long-term health problems were higher. Additionally, eighty percent of teenage mothers never graduated from high school, and only ten percent of those improved their earnings after age sixteen.\textsuperscript{53} Children of teenage mothers also often dealt with problems throughout their lives, including low earning potential and higher rates of imprisonment.\textsuperscript{54} All of these issues contributed to a kind of trap whereby teenage mothers and their children had a difficult time pulling themselves out of poverty, further contributing to current and future health problems. Although some of these issues, especially future earning potential and the possibility of incarceration, were not traditionally seen as health issues, the Project used teen pregnancy as an example of the complex interplay between health and social issues.

Clearly, black women and their families/communities were in a health crisis by the time of the founding of the Project, a crisis which did not appear to be ending any time soon. The issues discussed throughout this section were just a few of the health issues facing black women and their families, but it seems obvious that these problems signaled a larger health care crisis. What was also clear to Project leaders was that traditional notions of health and healing were not working for black communities, but neither were the alternatives, such as the women's health movement and the holistic health movement. As evidenced by the dismal health statistics, none of these conceptions adequately addressed the health concerns of black women. The Project would have to work to re-conceptualize women's health if they were going to be able to meet their goal of making improvements in the lives of black women.


\textsuperscript{54} National Black Women's Health Project, “Fact Sheet: Reproductive,” 3. In a survey at Attica State Prison in New York, researchers found that 90% of inmates were born to teenage mothers.
Health Re-Defined

Starting with the 1983 conference on black women's health issues, the Project forwarded a wholistic vision of health, one which insisted health was “not merely the absence of disease or disability, but a state of positive well-being, physical, mental, social, spiritual in its aspects.” For Project leaders, health definitions which were reductionist did not reflect the lives and health of most people, but especially women of color. As June Jackson Christmas, the keynote speaker at the Project's first conference, noted, race, class, and gender complicated the health and wellness of black women. Black women faced “financial barriers to health care” while also suffering “from those conditions to which poverty contributes.” Even wealthier black women suffered from higher disease and mortality rates than white women, suggesting a complicated relationship between economic class, race, and gender in regards to health care. Any conception of health and wellness which did not take these relationships in mind would not help black women in their journey toward wellness.

Although the Project had a fairly straightforward definition of health, achieving this vision of wellness would not be an easy journey. Individuals, communities, and health care providers would all have to make serious changes if African Americans were to reach a positive state of well-being. While the holistic health movement placed the burden of healing almost completely on the individual, the Project saw a complicated relationship between individual action and positive changes in health status. Project leaders cautioned its members not to fall into the trap of assuming the responsibility for health lay only in the hands of the individual and not partially in the hands of society at large. Rather, it was important for black women to “look at the

56 Ibid., 8-9.
role of society in bringing about and perpetuating conditions that interfere with health, place
people at greater risk of disease or produce growth-interfering conditions."57 Emphasizing the
individual's responsibility for health outcomes ignores the very real outside forces acting on
black women, negatively affecting their health.

However, the opposite was also true. Focusing only on the impact of social forces ignores
the role individuals play in their health. Christmas warned conference attendees not to overlook
their own responsibility in improving their health. During her keynote address, Christmas told
the audience:

if we become involved in social action to remove the inequities in
health care and to improve the health of black women as a group,
but maintain our individual destructive patterns of self-indulgence
in overeating, smoking, alcohol or drugs. . . then we will just be
as hypocritical as the dominant white society which professes
values of democracy and equality but keeps us as a people poor,
oppressed, powerless and ill.58

Although social conditions negatively affected the health of black women, Project leaders
wanted black women to realize that they could also impact their health, both positively and
negatively. Project leaders urged their members to make as many positive lifestyle changes as
they could while also recognizing the limitations of personal changes on individual and group
health status.

This is where the Project's self-help process came into play. As discussed in chapter two,

58 Ibid., 9.
the purpose of self-help groups was to empower black women by giving them the tools to begin re-defining what it meant to be a black woman and to work on overcoming internalized oppression. Empowerment was the first step to wellness, the Project argued, and empowered women were able to make changes in their lives to support their physical, mental, and spiritual well-being. As Avery herself noted, the self-help formula was

a simple one: a woman will feel better about herself when she knows that someone cares. Once she is provided with support, along with practical knowledge about her health, she will take steps that will ensure her continual well-being and that of her family.59

Eating healthier, exercising, seeing the physician, and ceasing smoking or drug use were all ways black women could improve their health and well-being. However, making these kinds of changes were difficult for un-empowered women, the Project argued. Once black women made themselves and their health a priority and changed any negative behaviors, they could help improve their health.

Defining individual and group health problems would also be a task for the self-help groups. Although early meetings would focus on empowerment, the group could also guide their meetings toward discussing specific health issues and individual experiences with health care providers. For example, the Project suggested that groups could discuss stress-reduction strategies, ways to eat healthy on a budget, environmental pollution, home/work safety, and

sexuality health. Talking with one another about these issues was critical, according to the Project, because often members “often didn't even know what conditions we are suffering under until we hear ourselves talking about it.” For Project leaders, and especially Avery, it was critical for black women to define their health issues for themselves, rather than have the organization place priorities on certain health concerns. As Avery noted, Project leaders did not need to approach black women with specific health issues in mind. She argued “we don't need to be going in there talking about 'Sister, go get your Pap smear'. That may not be what her health issue is. We've got to go in there and say, 'Sister, I'm here to support you or work with you. What is on top for you?'” The Project was there to facilitate the groups, not dictate their program.

While individual groups were encouraged to define their own health concerns, they were cautioned not to focus on one issue alone. “The concept of self-help groups organized around no specific disease entity makes the NBWHP's approach novel,” Avery wrote in 1992. A self-help group which focused only on one disease or health issue would not support the Project's wholistic vision of health. While individual meetings could center on a certain illness, the group's agenda as a whole was to reflect the NBWHP's wholistic conception. While self-help groups in other contexts often focused on one issue, the NBWHP wanted to ensure their groups reflected the lived experiences of black women. Thus, the self-help groups discussed a number of topics important to its members, reflecting the connections between physical, social, spiritual, and

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60 National Black Women's Health Project, “Self-Help Developers' Manual.” In the manual, the Project laid out potential meeting agendas for self-help groups. They listed five potential agendas. The first two meetings would focus heavily on empowerment. The third would more generally approach health issues, asking members to describe their health from birth to present. The fourth and fifth meetings were the time to start getting into specific health issues. These agendas were just guidelines. The Project allowed the group members to decide their own agendas.

61 Ibid.

mental health concerns.

Although individuals were responsible for making better health decisions, physicians and health practitioners also bore a responsibility for helping to change the health system, according to Project leaders. In particular, the NBWHP lauded physicians who approached their practices from a more wholistic standpoint, especially physicians who understood the connections between health and social conditions. At the 1983 conference, the Project invited Threasa Adderley, a family practice physician in Atlanta, to speak for the attendees and describe her unique practice. Calling it a “model program,” the Project praised Adderley for her clinic which stressed the relationship between the mind, body, and spirit and a person's social conditions. In Adderley's mind, being able to feed oneself or knowing how to deal with stress were just as important for one's health as getting antibiotics for bacterial infections. Thus, her practice emphasized the importance of discussing patients' social concerns with their physician.

For example, Adderley described how many of her patients would come into the office asking for valium to help them deal with their anxiety. However, rather than prescribing the medicine, Adderley would urge them to discuss their worries with her. According to Adderley:

> whatever [the patient's] needs are is what I want to address myself to do. So we will [find out about] where you can get extra food or emergency help to turn the lights on. . . These things are causing the anxiety that causes [the patient] to need that nerve pill. There's no reason to take a pill because it doesn't do anything. The next morning you are facing the same problem.

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Although learning about programs to help keep a person's electricity on, or finding ways to give patients food was outside the purview of most physicians, in Adderley's practice this was common place. In the biomedical model, for example, Adderley would give a patient with anxiety medicine to treat the symptoms. However, Adderley recognized the complicated relationship between social conditions and the physical/mental symptoms of disease.

Adderley also understood the very real financial barriers to good health, and worked with her patients in order to find a way for them to pay for her services. When patients did not have insurance or were unable to pay their bills, Adderley would often use the barter system, accepting garden vegetables or child care in lieu of money. No one was turned away from her practice if they were unable to pay.64 This helped remove many of those financial barriers, making it possible for black patients to seek out care before their problems turned into serious issues.

The way Adderley conceptualized health reflected the Project's own understanding. Patients could attend classes to learn about art, exercise, nutrition, stress-coping mechanisms, self breast exams, contraception, and cooking on a budget. Rather than simply focusing on disease cures, Adderley's practice stressed the importance of disease prevention. In this way, Adderley expected her patients to work with her, rather than rely on her to tell them what to do. “The doctor/patient” relationship was “a two-way street,” Adderley argued. She was not an omnipotent expert; rather, she was a teacher and a guide. “You don't go to school depending on them to teach you everything,” she insisted. “You teach yourself. You decide your destiny. . . some teachers made you think that they were next to God. You heard 'I'm a genius. I'm doing the

64 Adderley, “Model Program,” 54.
best work here.' I hope I never get to that point of making students feel I'm a genius.” She may have had more education than her patients, but Adderley insisted they knew as much, if not more, about their bodies than she did. Her job was to facilitate her patients' healing, not to dictate how they were to achieve it.

The Project also praised practitioners who were not medical physicians. In an issue of *Vital Signs*, the NBWHP's newsletter, Project member Kimberley Collins described the spiritual healing practice of Dr. Sharifa Saa. Describing herself as a “wholistic practitioner,” Saa's program worked to empower black women to restructure their lives in order to achieve wellness. According to Collins, Saa's services were similar to what one would receive from a psychologist, but her approach was different. Saa described herself as a wholistic practitioner because “if I just used one thing [to help women achieve wellness], that one thing may not be sufficient. What I'm trying to do is empower the person and I can't do that with a part. I can only work with the whole.” In particular, Saa emphasized the relationship between the physical, mental, and spiritual. Given that “spirituality is part of our natural makeup,” Saa argued that ignoring spirituality in favor of the mental or physical would lead to further problems in one's life.

Spirituality did not necessarily mean organized religion, according to Saa. Rather, it meant getting in touch with one's “inner spirit” and learning how to achieve one's goals. During her sessions, Saa worked to help clients understand “the big whys. Why did I stop myself from being what it was I wanted to be? Did I learn this lesson and if I learned this lesson what was that lesson? Do I want to repeat it?” Knowing the answers to these questions and understanding the relationship between the spiritual, mental, and physical were all keys to empowerment, Saa

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65 Adderley, “Model Program,” 54.
67 Ibid.
68 Ibid.
argued. Once empowered, black women could practice “self-love” and “find peace through health because when you are healthy you do the right things for yourself.”\textsuperscript{69} Healthy, empowered women were more likely to make better decisions for themselves and their families.

As an organization, the NBWHP also played a role in helping raise the health status of black women. Although the Project stressed the importance of individuals and health care providers in altering health care delivery for black women and their families, NBWHP leaders also believed they had a responsibility to help improve the health status of black communities. Through the self-help process, the NBWHP hoped to empower black women to make changes for themselves, and they urged members to improve their health status through individual action. Even though the Project tended to focus on empowering black women through the self-help process, the NBWHP understood that they would have to make institutional changes in order to address social barriers to wellness. As Patricia Hill Collins argues, it is often necessary for black women’s organization to “equip Blacks to struggle” before they can address larger issues. Collins goes on to assert “black women cannot be content with merely nurturing their families and communities because the welfare of those families and communities is profoundly affected by the injustices that characterize U.S. political, economic, and social institutions.”\textsuperscript{70} Although the Project tended to use most of its energy and resources to aid black women in making personal changes, they understood these changes could only go so far in improving black women's health.

In order to make systemic changes for black women, Project leaders knew they would have to involve themselves in America's social and political systems. Better access to health care, universal health insurance, improvements in the welfare system, and a more accountable

\textsuperscript{69} Collins, “Wholistic,” 16.
government were just a few of the issues the NBWHP worked to address at the national level. To this end, the Project founded an education and public policy office in Washington, D.C. in 1990 to facilitate their national political work. 71 Although the main headquarters stayed in Atlanta, Project leaders viewed the office in Washington, D.C. as a way to enter into the national political scene and affect changes for black women that would positively impact their well-being.

Project leaders defended their entrance into the political arena by arguing that no other group or organization truly understood the unique issues facing black women. Ama R. Saran, a NBWHP core consultant, called black women in the organization “guerillas in the midst,” warriors fighting against forces keeping black women sick, poor, and unhappy. As guerrilla warriors,

we must position ourselves to do right struggle-to come girded;
armed to do battle to protect what we build. We are Guerrillas in the Midst. In the midst of social and political upheaval, in the midst of historical and contemporary forces that threaten our lives at every level. 72

The Project insisted that it was engaged in a fight with “enemies in our ranks-those in the midst of us who deny us our every right to lead who, health, self-reliant lives.” 73 According to the NBWHP, black women were warriors who fought against the medical community, pharmaceutical companies, and legislators who did not actively fight for black women’s health needs. Self-help would empower black women to make individual changes, but it would also

71 Unfortunately, I have not been able to find out the direct funding source for the office in Washington, D.C. The NBWHP had grant funding from a number of institutions, but their available financial documents don't always make clear which grants supported which programs.
73 Ibid.
help produce activists dedicated to fighting for improvements for black communities. NBWHP members were “guerrilla warriors,” women empowered to boost black women's health at every level.

In particular, the NBWHP criticized the government for supporting a racist, classist medical system whose availability rested on a private, expensive insurance program. Project member Julia Scott chastised the United States for being one of the only industrialized nations not to provide its citizens with universal access to medical care regardless of an individual’s ability to pay. Scott called on Congress to create a “universal health care [system]- a single, equitable system dedicated to serving all of us.”\textsuperscript{74} Universal insurance would help guarantee access to adequate health care, a requisite for reaching true wellness. After all, as Project leaders argued, many of the serious health problems facing black women could be cured or alleviated by access to medical care. While other nations worked to expand citizens' access to medical care and facilities, the Project spoke out against the American government for actually making it more difficult for poor Americans to find adequate medical facilities. Activist and Project member Angela Davis assailed the Reagan administration for closing down hospitals in poor black communities, as well as hospitals that trained black medical students, future physicians who would be more willing to work in poor, urban communities. According to Davis, under Ronald Reagan’s administration, in central Harlem, a predominantly poor black community, there was only one doctor per 4,500 people, while the national average was one doctor per 1,500 people.\textsuperscript{75} These statistics were troubling because these hospitals contained the trauma centers that treated victims of violence and those unable to pay for medical care. In addition, only 44.1

percent of black sought care from private practice doctors; the other 26.5 percent sought medical care from hospital emergency rooms. These hospitals were critical health care facilities in poorer black communities. Many women of color did not have the funds to seek care from private physicians so they sought medical attention from hospitals in their communities. According to the National Medical Association, 25 percent of blacks had no medical insurance, and 23 percent did not have a consistent source of medical care.¹⁶ Many black Americans, especially women, utilized emergency rooms for medical care, even for fairly minor health problems, because it was illegal for emergency rooms to turn away patients or women in labor.¹⁷ For women without insurance, these hospitals were a crucial place to seek medical care. Although emergency rooms often provided only a stop-gap form of health care, the NBWHP fought to stop the closing of these hospitals and pushed for a universal health care system.

The issues of insurance and health care access were intimately connected with another concern of the NBWHP, the privatization and commodification of health care. This process, supported by the American government, had “prioritized the profit-seeking interests of monopoly corporations, leaving the health needs of poor people—and especially poor Black women—to be callously juggled around and, when need be, ignored.”¹⁸ According to Davis, “for-profit” hospitals often moved welfare recipients, most of whom were black women, to public hospitals whose care was often not adequate. In order to provide better medical care for women, despite the privatization of health care, the NBWHP, in alliance with the Children’s Defense Fund, a children’s advocacy group, urged the government to add an amendment to Medicaid that would provide coverage to all pregnant women and infants under the poverty level. In addition, they

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¹⁷ Ibid., 338-339.
insisted the government provide more funding for WIC (Women, Infants, and Children) in order to combat malnourishment. Both the NBWHP and the Children's Defense Fund argued that adequate medical care, specifically prenatal care, should be viewed as a “birthright instead of a privilege” that should be guaranteed to all women despite economic status.\textsuperscript{79} Since legislation such as WIC and Medicaid provided many poor black women with health care and food support, the NBWHP saw this advocacy work as a direct way to address some of the serious issues affecting black women's health.

In order to address the poor health status of black women, the NBWHP worked to develop a concept of wellness and health activism which would address the realities of being black and female within the U.S. The Project emphasized the importance of the self-help process in empowering black women to make better health decisions and to work to also improve their communities' health. In support of these goals, the NBWHP forwarded a wholistic notion of health which would address the lived experiences of black women. Ideologically, it made sense that the Project would have to re-define health and health activism as their members worked to re-define black womanhood. The question, though, became how would these two concepts work on a practical level? How would the organization combine self-help and wholistic health care in order to bring about meaningful changes in black communities? Although the Project launched a number of programs during its first five years, its Center for Black Women's Wellness most clearly shows the ways in which self-help and a wholistic vision of health worked together to improve the wellness of black women and their families.

**The Center for Black Women's Wellness: A “Link Between Services and the Underserved”**

One of the most important and enduring NBWHP program, the Center for Black Women's Wellness:

Wellness (CBWW) opened its doors in Atlanta in 1988. Combining two tenets of the Project's guiding ideology, self-help and wholistic health care, the CBWW offers scholars a window into how these two concepts worked on the practical level. The CBWW first opened its door within the McDaniel-Glenn public housing community, a now demolished public housing community in the economically disadvantaged Mechanicsville neighborhood in Atlanta. With the financial support of a three year grant from the W.K. Kellogg Foundation, the Center hired a small staff and began developing a model to deliver health care/wellness services to women and adolescent girls living in the McDaniel-Glenn public housing community. In establishing goals for the CBWW, the Project envisioned a center which would provide health services to over 300 women and girls, counsel clients wishing to utilize social services, develop self-help groups amongst residents, and establish an arts program. Throughout its years of operation, the Center's goals evolved and expanded, but its original goals supported the Project's idea that a health center should treat black woman wholistically. An analysis of the CBWW reveals how these two important concepts, self-help and wholistic health care, worked together to help black women achieved desired levels of wellness. What would a wholistic health center look like? What was the relationship between the NBWHP's self-help process and improvements in black women's health status? The CBWW provided one answer to these serious questions.

The Project chose to locate the Center in an economically disadvantaged area in order to provide services for women underserved by both the medical community and social services. As Project leaders noted, the targeted public housing community had seen many projects aimed at helping residents, only to watch these programs disintegrate when funding ceased. To counteract

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80 The W.K. Kellogg Foundation was established in the 1930s by Kellogg Company founder, W.K. Kellogg. The Foundation offers grants to organizations dedicated to improving the health and education of children, as well as groups dedicated to racial equality. More information on the W.K. Kellogg Foundation can be found on its website, http://www.wkkf.com.
the understandable feelings of mistrust residents might have toward Project members, the Project instructed member Cheryl Boykins to begin working in the community, developing relationships with its residents. The CBWW managed to develop trust amongst residents quickly, aiding in its success within the community. In discussing their choice of location, Center staff described some of the major health issues facing impoverished black women throughout the U.S. For example, the Center pointed to decreasing numbers of childhood vaccinations among black children, the AIDS epidemic, the use of emergency rooms as the primary health care provider, the closing of hospitals and public health clinics in black communities, routine sterilization of black women, and the depersonalization and fragmentation of various welfare bureaucracies as some of the most serious health problems facing black women.\textsuperscript{81} Almost all of these issues, according to the CBWW, could be traced back to the complex consequences of poverty and minority status. These consequences were “often invisible and usually ominous” for black women's health and well-being, the Center argued.

In particular, poverty and reliance on social services negatively affected black women's health. By the time of the Center's opening, President Ronald Reagan had rolled back many of Lyndon Johnson's Great Society programs, especially those aimed at helping the non-elderly poor such as Aid to Families with Dependent Children and Food Stamps and child nutrition programs.\textsuperscript{82} Largely in response to the major recession of the early 1980s, Reagan justified these cuts as necessary to getting the federal budget under control and protecting taxpayer dollars from welfare recipients who were allegedly bilking the system.\textsuperscript{83} These cuts had immediate and long-

\textsuperscript{83} Ibid., 134-135.
lasting affects on the lives of welfare recipients, especially black women. As CBWW director Cheryl Boykins described, when state and federal governments cut back on entitlement and welfare programs and developed more strict eligibility criteria in times of financial crisis, the minimal resources available to poor black women decreased. A vicious cycle began where economic recession led to increased unemployment and tax shortfalls. The already overtaxed system saw itself flooded with more impoverished Americans, and decreases in funding meant that fewer of the impoverished received assistance when the need was at its greatest. Cutbacks in nutrition and food programs placed a further burden on black mothers charged with caring for their families, causing additional physical and mental stress.

This lack of support contributed to “increased hopelessness among the socially disenfranchised,” Boykins argued, because the “depersonalizing and fragmented services delivered by overworked welfare bureaucracies contribute to increased cynicism and hostility in those they were designed to serve, and these psychological conditions are known to be associated with health.” Cynicism, hostility, and anger all negatively impacted minority's health status, according to the Center, leading to health issues such as hypertension, coronary heart disease, and other chronic illnesses. Along with these physical effects, impoverished Americans also suffered from psychological problems in greater numbers than the economically privileged. In a funding proposal to extend the financial support of the W.K. Kellogg Foundation, Boykins argued “decades of feeling blamed for the very circumstances that entrap them have led persons in this population to have an increased sense of impotence and helplessness, low self-worth, and social isolation, all of which are negative health indicators. Many despair not only of influencing

85 Ibid.
social change but of taking any meaningful action in their own behalf.” It was this feeling of impotence, according to Boykins, that kept black women locked in a place of hopelessness, unable to make meaningful changes in their lives. Although individual women may not be able to bring health clinics into their communities or increase federal spending on welfare programs, the NBWHP continued to believe there were a number of changes black women could make in their lives to improve their health.

Making these changes would be difficult, however, if these women did not overcome feelings of helplessness. This is where the self-help process came into play. Boykins describes the CBWW and the self-help process as an intervention that replaces despair with self-respect and self-knowledge, that replaces cynicism with hope, that replaces helplessness with a sense of personal power, that replaces social isolation with personal connectedness and a sense of community, and that replaces a legacy of shared shame with a vision of shared confidence for the future.

The self-help process, as discussed in chapter two, involved small groups of black women discussing their lives and health with each other. Participating in a self-help group allowed women to learn about themselves and their health in a safe, non-threatening environment. In these groups, women would describe and re-experience feelings they had surrounding past events. Within these safe spaces, group participants would express their feelings to other non-judgmental participants, freeing them to confront and analyze the situation, allowing them the space to explore their own decision-making process. The groups were particularly important,

87 Ibid.
according to Boykins, because “the people most affected by a problem and who live with it daily often carry the solutions within themselves.”

As Byllye Avery had often said, black women needed knowledge about their health, but without a sense of empowerment, making these changes would be difficult, if not impossible. The self-help groups aided women in developing their own solutions to their health problems. After all, who would know better what women needed from their lives and their health care than the women themselves?

It was this belief, that women best knew what they needed from both the self-help groups and the Center, that led the CBWW to hire staff who were residents of the housing community. This meant that “women who call or come into the Center are met by their own neighbors, who understand full the complex characteristics of life as a black woman in public housing and therefore who can serve as models for self-empowerment.”

Through their work in the CBWW, Project leaders argued, staff would continue to develop their own personal power, making better decisions for themselves and modeling this behavior. Instead of a vicious circle where women felt impotent and hopeless, the Center would begin a circle of empowerment where clientele would see the self-help process' success in CBWW staff, and clients could then take this process into their communities.

Instead of treating their clients as solely responsible for their economic position or negative health status, Center staff worked to aid their clients in finding their own solutions to problems. Staff members and Project leadership believed that “enduring solutions to individual problems must be rooted in personal resources.” Thus, “clients are treated not as the 'poor victims' of circumstances but as persons of dignity who can develop power through self-

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understanding and caring relationships with others. To foster this goal, the Center was advised
by an advisory council, made up of community members, who identified any problems in the
Center and developed solutions to these problems. The advisory council was also tasked with
seeking potential community resources and expanding the work of the CBWW. This ensured
that community members worked alongside staff members, each aiding in the other's
empowerment.

The self-help groups were truly life-changing for many of the Center's clients, and the
CBWW estimated that at least 750 residents attended a self-help group at the Center. In a
1990/91 evaluation of the CBWW, researcher Douglas J. Stanwyck oversaw a series of
interviews of Center clients. Many of those interviewed described their new found strength and
confidence after participating in the self-help process. One client explained how the self-help
process allowed her to begin to work on herself and have a “more positive [view] of myself.”
Another participant found that an important part of the self-help process was “beginning to rely
more on yourself and the motivation, you all can have that motivation, because it's got to come
from within.” One client simply stated, “I know that if I'm not determined to help myself, ain't
nobody else gonna help me out.” Change required personal commitment, and the self-help
process empowered women to commit themselves to positive change.

On an emotional level, the self-help groups allowed participants to express their feelings
and break the conspiracy of silence by making connections with women going through similar
situations. One Center client, simply called “L” in the 1990/91 evaluation, explained how the
self-help process helped her grapple with an abusive relationship. According to “L,”

91 Ibid., 3-4.
92 Ibid., 20.
93 Ibid., 29.
I was a parent, and a wife, and my husband used to jump on me all the time, and beat on me, and I would just take it, and I would always keep to myself, I wouldn't tell anybody. I was always told not to talk, not to tell anything. Since I came to the Center I'm able to talk more about it now, and I feel at ease, and I'm not alone, so I've other women that's [sic] been going through the same thing, or even worse than I have, but we're able to talk about it. I wasn't able to tell anybody how I was feeling inside, but now I'm able to really talk [it] out and let people know what's going on with me.94

For “L,” being able to discuss her feelings about the abuse freed her, allowing her the opportunity to make connections with other women facing similar issues. The self-help group experiences empowered “L” to make changes to her life, allowing her to gain control over her life and relationship, improving both her physical and mental well-being.

Although self-help was important to the CBWW's program, clients received a number of other services from Center staff. In his report on the CBWW, Stanwyck described a typical first visit for a Center client. First, a staff member called a wellness developer (who was rarely a physician), filled out an intake form and spoke with the client to see if the client was in crisis. If the patient was in some form of crisis (e.g., eviction, loss of job, or nonpayment of utilities), the staff member helped find a way to deal with this immediate crisis. Once the crisis was dealt with, the client attended an orientation with a staff who discussed the Center's philosophy, assessed the patient's needs, and made recommendations and referrals when appropriate.95 From there, clients

95 Ibid., 5.
could utilize the many services the Center offered.

The CBWW offered a wide variety of services to their clients, and worked closely with the community to develop a program which would meet the needs of the housing community residents. The services they offered were myriad and included, but were not limited to health screenings, assistance with social services, vocational training, and G.E.D. courses. In collaboration with the surrounding community and social service organizations, the CBWW helped facilitate the development of a summer teen employment program, a Headstart program, founded a Girl Scout troop, helped recruit teenagers to Job Corps, and helped enroll women in an Opportunities Industrialization Center training program. Reflecting the Project's wholistic vision of health and wellness, these services and programs sought to address the physical, mental, social, economic, and spiritual wellness of the Center's clients.

The majority of Center client's first visited the CBWW for health screenings. CBWW staff were trained to perform pap smears, breast exams, pregnancy tests, STD tests, urinalyses, blood pressure screening, and other primary prevention health services. Although the Center could not always treat all of the potential illnesses their screenings discovered, the Center consciously built relationships with other agencies and clinics/physicians so they could refer their clients to seek further care. Treating these illnesses were less important to the CBWW than arming clients with information to make their own health decisions. Sending clients to a clinic or physician armed with a diagnosis often made the women feel they were in a more equal position

97 Boykins, “Proposal,” 3. The Opportunities Industrialization Center was (and continues to be) a program which worked to provide education and job training to economically disadvantaged men and women. More information on the OIC can be found on the organization's website, http://www.oicofamerica.org.
98 Cheryl Boykins, “Empowerment is the Essence of Healing is the Essence of Wellness” Vital Signs No. II (1992), 13; Stanwyck, 16.
with the physician. As one client interviewed stated, “you know, if we have to go to the doctor, we better already know our diagnosis before we go to the doctor because they'll tell you anything to get your money, you know.” Through the self-help process, clients would be empowered to take information from screenings, which included information on their illness and possible treatments, and make decisions they believed would most positively affect their health and wellness.

CBWW clients suffered from a variety of health problems, only a handful of which were considered traditional women's health issues. In order of prevalence, clients indicated they suffered from, or wanted to be screened for, hypertension, anemia, migraine headaches, STDs, and allergies. Reflecting the NBWHP's wholistic approach to health, Center staff did not simply screen for the health issues client's listed. Rather, patients received a comprehensive exam which included nutritional, gynecological, and mental health counseling. CBWW staff made sure to explain the purpose of specific screening procedures, and they taught women how to recognize early symptoms of diseases. Clients were shown how to perform breast self-exams and “other aspects of physical self-care.” It was clear to the NBWHP, based on Center intake forms, that black women were suffering from a variety of issues, only some of which were related to women's reproductive organs and reproductive capacity. Rather, reproductive health concerns were just one of a variety of issues black women dealt with on a daily basis.

Many clients certainly felt empowered by the screening process. For many, their experiences with wellness developers were some of the few positive interactions they had with a health care worker. According to one woman, “I have never felt like they, [physicians] were

100 Stanwyck, “Final Report,” 27.
102 Stanwyck, “Final Report,” 17. Unfortunately, the sources aren't clear on specific examples of physical self-care other than breast self-exam.
concerned about my body, or concerned that I may have concerns about my body, and that it was my body and I wanted to know what was going on. Usually . . it becomes their body, they do whatever they want with it . . there's no communication." 103 As the NBWHP had shown time and again, black women rarely felt like physicians treated them with respect, empowering them to make decisions on their own plan for care. CBWW staff, however, treated women with respect, handing them the tools for health and wellness. Another client discussed her experiences with a CBWW staffer, saying

she worked with me. She was able to give me little hints on what I had to eat, because I have high blood pressure, and she takes time out . . she's real helpful. It's a good experience to know that you can come somewhere and get the information and know that somebody's going to treat you right and not tell you you need to lose weight because you're too fat, but have somebody tell you you need to lose a little weight to keep your blood pressure down . . she's able to tell you in a way that you want to come back. 104

Wellness developers, as members of the same community and women often suffering from the same issues, approached clients from a place of equality, giving them health information and treating them with respect, empowering them to make better health decisions.

Second only to health screenings, clients sought help from the Center concerning social and economic problems. The NBWHP saw the CBWW as a “link between services and the underserved,” a bridge between the fragmented health and social service agencies and women

104 Ibid., 27.
most in need of these services. According to the CBWW, “cumbersome bureaucracies, heavy case loads, limited resources, and negative social attitudes all contribute to the depersonalization of clients and to the perception of clients that they must 'swallow their pride' in order to obtain these services.” The Center, in order to improve access to social services, developed relationships with social agencies in order to coordinate “service delivery,” and to educate themselves on services their clients might need such as food stamps and financial assistance. Center staff consulted with clients to find help with rent and utility payments, financial support to purchase food, furniture, and bedding, and access to adequate housing. As the CBWW understood, these kinds of crises were often more important to the physical and mental well-being of impoverished women than pap smears or vaginal self-exam.

Dealing with these immediate crises helped improve clients' well-being in the short term, but the Center also worked to provide clients with the skills to improve their economic position in the long-term. The connections between socioeconomic conditions and individual/community health status were clear to the NBWHP, and the CBWW programs sought to “better health through jobs and skills counseling referrals.” The CBWW offered G.E.D. courses, vocational training, and employment assistance to clients. They especially targeted teenagers, hoping to arm them with these skills early, making it easier for them to improve their long-term earning potential. Financial security gave women access to better housing and health care, and lessened the stress of financial instability, leading to a greater sense of emotional and mental well-being which also positively impacted one's physical health.

The majority of CBWW clients believed they were helped by the Center's programs. In

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107 Boykins, “Proposal,” iii.
particular, clients lauded the self-help process, praising the CBWW for helping them overcome their feelings of helplessness. As one client remarked, after working with the CBWW “I feel that I can accomplish anything that I set my mind to do, and I feel like [nothing] can keep me from becoming the person I want to become, and do the things that I want to do.”\footnote{Stanwyck, “Final Report,” 31.} Another simply stated that, after her work in a self-help group, “I'm very much in control of my life, and that's a good feeling to have, control of your life.”\footnote{Ibid., 33.} Once empowered through the self-help process, Center clients used the health information provided by the CBWW to make better health decisions.

And many clients did make better decisions for themselves and their families after becoming involved with the Center. Stanwyck found that many women noted they had made serious changes in diet, self-care, and in personal relationships. Clients drank more water, ate less salt, stopped drinking alcohol, and took care of their emotional needs, often for the first time in their lives. This commitment to taking care of oneself often expanded to a commitment to helping other black women achieve wellness. One woman poignantly described how her life changed after she came into the Center with a grapefruit-sized lump under her arm. Diagnosed with breast cancer, she had to have a radical mastectomy. As she told Stanwyck,

\begin{quote}
I made a promise to you [the Center staff] that I would take care of myself. . . but I think I made another promise to you, I said that when this [her treatment] as all over, I was going to volunteer, I was going to help somebody.\footnote{Ibid., 38.}
\end{quote}

This client began volunteering at an Atlanta hospital's oncology clinic and offered to lead a

\begin{flushright}
\footnote{Stanwyck, “Final Report,” 31.}\footnote{Ibid., 33.}\footnote{Ibid., 38.}
\end{flushright}
workshop on breast cancer prevention at the Center, all in the hopes of empowering others to make their well-being a priority.

In part, these clients felt empowered to make changes due to the Center's wholistic approach to health care. “I feel like here [at the CBWW] that you have the concept down that the body is made up of several pieces, and no matter what piece you may be treating, that you have to deal with person as a whole person,” another client remarked. “I don't think that you can even talk about making an impact on women's lives if you do not deal with the whole person, no matter what specialty you may be in, you've got to deal with every piece of it, mentally, physically, emotionally, everything.”\textsuperscript{112} Reflecting on her experiences with her gynecologist, client “D” described how they physician did not connect her chronic vaginal infections with other aspects of her life. “They never asked me what I was eating, they never asked me if I was under a lot of stress. I was like they just treated that piece,” she told Stanwyck.\textsuperscript{113} For the first time, these clients had found a place that would address all of their issues, whether they be physical, economic, or emotional, and work with them to find solutions.

Still in operation, although now independent from the NBWHP, the CBWW has helped improve the well-being of thousands of black women in Atlanta. The integration of self-help and the Project's wholistic vision of health within the Center proved to Project leadership that these two concepts worked together to address the unique health concerns of black women. Future Project programs would continue to spread the self-help process while supporting a wholistic vision of health care, the two most important legacies of the first years of the NBWHP.

The NBWHP firmly believed that the plight of African American women was intimately

\textsuperscript{112} Stanwyck, “Final Report,” 40.
\textsuperscript{113} Ibid., 26.
connected to the health of other women of African descent, and they began looking for ways to spread their programs into other nations. How would self-help and wholistic health care work in communities outside the United States? What sorts of relationships would the Project have with women from very different communities? At home, Project leaders recognized that their own goals often overlapped with those of white health feminists, especially their mother organization, the National Women's Health Network. How would the Project work alongside this predominantly white organization? Additionally, other women of color, including Latinas and Native Americans, began working to found their own health organizations. Looking to the Project for inspiration, these groups began adopting and adapting self-help and wholistic health in order to improve the health of their own communities. Thus, by the late 1980s, the Project found itself in a unique position. They would have to grapple with their position as the vanguard of the women's health movement, fostering connections between themselves and health activists both at home and abroad.
Chapter 4
Pragmatic Alliances: Working with Other Women's Organizations

On April 5, 1992, in response to the Supreme Court's hearing of arguments on Planned Parenthood v. Casey, a case concerning a Pennsylvania law restricting some abortions and requiring additional consents for the procedure, over half a million women and men walked the streets of Washington, D.C. during a “March for Women's Lives.”¹ The event, the largest march in the capital up to that time, was organized by the National Organization for Women (NOW) under the leadership of Patricia Ireland.² Although NOW leaders considered the march to be a great success, this success was tempered by anger, disappointment, and resentment on the part of women of color, especially Byllye Avery and Julia R. Scott, the NBWHP's director of policy and education.

The controversy surrounding the event began when seven groups consisting of women of color sent NOW a letter expressing their anger for NOW “not honestly and effectively confronting the issue of inclusion” of women of color in the planning of the march. According to the letter's authors, NOW had ignored women of color in the planning stages, did not include them in the process of selecting speakers, and failed to respond to their request to allow a group of women of color in the front of the marchers. Charon Asetoyer, the director of the Native American Women's Health Education Resource Center (NAWHERC) and Luz Alvarez Martinez,

¹ In particular, the Supreme Court heard arguments on the constitutionality of five sections of the Pennsylvania law. These included 1) a rule requiring physicians to explain potential health risks and complications of the abortion procedure to patients, 2) spousal notification requiring wives to give their husbands notice before the procedure, 3) parental consent for minors, 4) a mandatory twenty-four hour waiting period between requesting the procedure and having it performed, and 5) a requirement for clinics performing abortions to keep certain records and reporting figures. The Supreme Court upheld the constitutionality of statutes 1, 2, 3, and 5.
the founder of the National Latina Health Organization, were both asked by NOW staff to speak and both refused. According to Asetoyer, “instead of working in a collective fashion, they just asked me to speak.” She went on to argue that she would not “rubber-stamp their [NOW’s] decisions.” Both Asetoyer and Alvarez Martinez resented NOW's perceived refusal to include them and other leaders, especially Bylye Avery, in the planning of the march. Although they disagreed with NOW's planning of the event, the letter's authors encouraged women of color to attend the march, citing its importance in supporting a woman's right to abortion. However, the authors asked marchers, especially women of color, to wear green armbands to protest the NOW board's lack of inclusivity.³

In response to these concerns, NOW president Patricia Ireland met with Scott, Asetoyer, and Alvarez Martinez in the hopes of coming to an agreement concerning the march. Ireland, citing a scheduling conflict, stayed for less than an hour. Although NOW's board argued Ireland had made her tight schedule clear to the three women, Scott, Asetoyer, and Alvarez Martinez took this as evidence of NOW's lack of interest in the concerns of women of color. This feeling only deepened when NOW announced that women were to wear green ribbons in support of women of color. According to Scott, NOW was “trying to co-opt our protest.”⁴ The green armbands were meant to be worn as a statement against NOW's leadership; the green ribbons would only detract from this protest.

All of these issues with the march, according to Scott, pointed to NOW's true feelings toward women of color. “Their rhetoric” concerning women of color was fine, “but it doesn't matter what you say, it's what you do.”⁵ Shutting women of color out of the planning process at

⁴ Ibid., 89.
⁵ Ibid.
nearly every level while asking only certain women to speak smacked of tokenism to Scott. NOW wanted women of color to march to legitimate their agenda, but the organization's leaders did not seek to involve women of color in any meaningful way. Although, as Ireland pointed out, one-third of NOW's board included women of color, Scott, Asetoyer, and Alvarez Martinez believed NOW needed to be more inclusive of women of color in other organizations, especially those focused on women's health and reproductive justice. The March for Women's Lives, which could have been a symbol of the power of coalitions amongst women, became an event mired in anger and controversy.

As an event, the 1992 March for Women's Lives reveals a great deal about the relationships between feminists of various races and ethnicities. Issues over race and inclusivity had the power to divide feminists of different races, even when activists had similar goals. As numerous historians have discussed, interactions across racial, ethnic, and class lines were complicated at best, fraught with tensions and misunderstandings more often than not.6 Throughout the Women's Liberation Movement, white feminists developed a “gender universalist ideology, one that privileged gender oppression above others and that tended to blur racial and ethnic difference among women.”7 As Benita Roth argues, this was a strategy designed to bring together women across a number of potential barriers. However, women of color were not won over by the concept of a universal sisterhood. In her analysis of black feminist


7 Roth, Separate Roads, 188.
organizations, Kimberly Springer lists four reasons why black women did not respond positively to white feminist conceptions of sisterhood. First, many black women feared their involvement in feminism might increase tension between themselves and black men. Second, a number of black female activists worried their attention to gender oppression in a separate movement might divert their time and energy from the Civil Rights Movement. Finally, black women noted the distrust which existed between black and white women as well as the presence of racism and stereotyping within the women's movement. As Springer notes, however, many black women were sympathetic to many of the aims of white feminists and their organizations.

Rather than join with white women, many black feminists chose to organize separately, making black feminists more visible in the process. Voicing black women's concerns would not be impossible in predominantly white women's organizations, but these activists recognized that white women's groups generally organized around their own issues. Thus, “organizing one's own” became necessary to the development of a separate black feminist ideology. And by the mid-1970s and early 1980s, as Winifred Breines shows, black feminists had gained a significant amount of clout through their separate organizations, demanding that white feminists take women of color's experiences seriously. They “challenged white feminists to examine and understand their racism and convert the movement into one in which women of all races and ethnicities were recognized, were affirmed, and could operate fully.” Confronting difference, rather than erasing it through the acceptance of a universal sisterhood, became central to the

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9 Roth, *Separate Roads*, 200. Roth explores this ethos in greater detail in her section on relationships between various feminists. Ibid., 200-211.

10 Ibid., 151.
struggles between feminists.

A consciously feminist organization, the NBWHP emerged out of the feminist movement, breaking away from the predominantly white National Women's Health Network (NWHN). As discussed in chapter one, the Project separated from the NWHN in 1983 during the first conference on black women's health issues. Throughout the conference, participants discussed how black and white women's health concerns differed, and Project leaders began the process of re-defining health and health activism for its participants. Although founder Byllye Avery did not originally conceive of the NBWHP as a separate organization, calls from conference participants convinced her the group should break away from the NWHN. As conference participant Loretta Ross recalled, “there were 1,500 women in the Sisters Chapel [on Spelman's campus] that said to [Byllye Avery], [']what're you going to do for us, Byllye, because we don't want to be with these white women'.“\(^{11}\) Although Avery had friendly relationships with white activists, she believed the calls for independence “were right. They were absolutely right.”\(^ {12}\)

Autonomy was integral to improving black women's health, according to Project leaders, because only black women could truly understand the unique challenges they faced. As the authors of *Undivided Rights*, one of the few books analyzing women of color's health activism, stated, “by establishing organizations that were racially and ethnically specific and separate from white organizations, women of color created the visions and gained the support necessary to raise the visibility of their. . . health concerns.”\(^ {13}\) Only by acknowledging difference and organizing independently from white women could black health feminists articulate an

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12 Avery interview, 31.
independent vision of health, one which addressed the concerns of black women.

This process of organizing independently was one advocated by black feminists in a variety of groups. The ideas of separation and independence were not invented by black activists, however. Scholars have noted that feminists generally split from New Left groups because these organizations were not adequately addressing the problems of sexism. Crafting a shared identity based on sex discrimination helped bring women of disparate backgrounds together. As discussed, however, this shared identity helped to erase racial and class differences. Thus, black feminists began calling for an “identity of their own,” articulating a need for black women to join together to fight against sexual, racial, and class oppression. This position was advocated by a number of black feminists including the Combahee River Collective, a group of black feminist socialists based in Boston, who “proclaimed the task of combating simultaneous oppressions as theirs because other movement failed to acknowledge their specific oppression.” White women were not necessarily working for the liberation of black women, the Collective argued, which meant that black women would have to liberate themselves. In essence, the Collective saw identity as a base for organizing black women. This process, which they called identity politics, created a space where an “oppressed group may organize to change their situation, as well as their feelings of self-worth and place in the social structure,” activities which necessitated independence.

A number of scholars have criticized this process of separation, arguing that identity politics were so divisive that they distracted from larger issues, harming social movements. These critiques assume, however, that identity politics preclude various groups from working

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with each other. To the contrary, identity politics actually fostered alliances and coalitions. According to Diane Fowlkes, as black feminists began to articulate an interlocking theory of oppressions, which included gender oppression, “they changed the dynamic of identity politics from separatist to coalitionist.” They were not leaving the feminist movement; rather, they were seeking to build relationships with those who sometimes benefited from the “interlocked system.” Although it was not an easy process, the NBWHP worked to develop “pragmatic alliances” with other women. Indeed, NBWHP leaders stressed “philosophical solidarity” with “women of other ethnic groups who are struggling toward similar goals from their differing historical positions.” For the Project, autonomy did not prevent them from building coalitions or alliances with other women working toward similar goals. The differences that had required their independence were not so large as to be impossible to overcome. Women of various races, classes, and ethnicities could work together, Project leaders believed, as long as these groups worked to understand their own unique historical positions. White women would have to grapple with racism in their organizations as women of color struggled to overcome internalized

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16 Stephanie Gilmore defines identity politics as “a framework and basis for activism and the pursuit of cultural and/or political change that is rooted in the interests of a particular group in society that shares experiences of real or perceived oppression.” Her examination of feminist coalitions explores criticisms of identity politics in greater detail. Gilmore, Feminist, 7. Barbara Ryan's introduction to Identity Politics in the Women's Movement provides a nice overview of the critiques of identity politics by both feminists and scholars. Ryan, “Introduction,” 1-16.

17 Diane Fowlkes, “A Writing Spider Tries Again: From Separatist to Coalitional Identity Politics,” in Identity Politics in the Women's Movement, ed. Barbara Ryan (New York: New York University Press, 2001), 281. It is also critical to note that there is an important difference between separatism and autonomy. Although the NBWHP did separate from the NWHN, they sought to be autonomous and did not advocate for separatism. In the introduction to the black feminist anthology Home Girls, black feminist activist Barbara Smith argues that “autonomy and separatism are fundamentally different. Whereas autonomy comes from a position of strength, separatism comes from a position of fear. When we're truly autonomous we can deal with other kinds of people, a multiplicity of issues, and with difference, because we have formed a solid base of strength with those whom we share identity and/or political commitment.” Barbara Smith, “Introduction to Home Girls: A Black Feminist Anthology,” in Identity Politics in the Women's Movement, ed. Barbara Ryan (New York: New York University Press, 2001), 157.

oppression. Once activists began taking these tasks seriously, Project leaders argued, female health activists could work together despite these differences.

The NBWHP was clearly dedicated both to identity politics AND coalition building. Although it appeared to many that these concepts were mutually exclusive, the Project shows how these two could work in harmony within an organization. Given Byllye Avery's close relationship with white activists, it would not have made sense for the group to break off ties with white organizations. Rather, the NBWHP worked to facilitate understanding between the two groups. Through their program “Sisters and Allies,” the Project worked alongside white women, teaching them about the Project's self-help process and pushing them to confront both racism and potentially debilitating guilt surrounding racism. If white health feminists wanted to build an inclusive movement, the Project argued, they would have to confront the barriers they erected between themselves and women of color. Although not always successful in convincing white women to use the self-help process to understand racism and their relationships with women of color, the “Sisters and Allies” conference shows how identity politics did not preclude relationships between black and white women.

Perhaps more importantly, however, were the relationships the Project built with other women of color. An area lacking in historical research, the alliances formed between black, Latina, Asian, and Native American women reveal the ways in which women of color worked together despite important cultural differences. Although many black feminists, except those in the Third World Women's Alliance, did not prioritize working with Latina, Native American, or Asian women, the Project did, in fact, see a reason to ally itself with other organizations founded by women of color. The Project only accepted black women as members, but other women of
color worked closely with the NBWHP, modeling their own organizations on the Project. Viewing the group as a pioneer in the women's health movement, Project leaders encouraged other women of color to organize themselves, insisting than an inclusive movement could not exist until Latina, Native American, and Asian American women made their own health needs a priority. Too often, women of color were viewed as a monolithic group, and the Project's work with these women reveals the many unique concerns that were not always shared by women of color despite their minority status. Project leaders felt a sense of solidarity with other women of color based on their racial, gender, and class oppression, but acknowledged that differences between the groups meant that independent organizations would be necessary.

Although the Project's self-help process and its wholistic definition of health were important legacies of their involvement in the Women's Health Movement, its most exceptional legacy was the role it played in making the movement more inclusive. Serving as inspiration to women of color both home and abroad, the NBWHP became the vanguard of the movement, forcing health activists to confront difference while also bridging these divides. The Project helped foster a community for activists of color, a community which would support women of color as they formed their own organizations. Independence would not fracture the movement; to the contrary, independence would force the movement to become more inclusive. When women of color began to organize independently, they were able to define their own priorities, articulate their own needs, and work toward improving the health status of their members. As Avery herself noted, one of the most important questions she asked as she worked in the Project was what was the difference between black, white, Latina, Native American, and Asian American health issues? By asking this question, and encouraging women of color to organize independently, the Project
was able to open up the Women's Health Movement, making sure that the movement would be more inclusive and thus more in tune with the health needs of American women.

**Sisters and Allies: White Women and the NBWHP**

The NBWHP had a long, productive relationship with other organizations, especially groups that were predominantly white. Although the Project became independent from the National Women's Health Network (NWHN) in 1983/4, the group continued to ally themselves with the NWHN and other predominantly white groups when their interests and priorities overlapped. Although this is not a comprehensive list, the Project worked with other organizations on issues such as abortion rights, gay and lesbian health issues, prison reform, birth control access and abuse, midwifery, and heart disease.\(^{19}\) Allied with a variety of groups, such as the American Heart Association, the NWHN, the National Organization for Women (NOW), and the American College of Nurse Midwives, the Project clearly prioritized bridging difference to work with activists with varied priorities and interests. Although the specifics of these individual alliances illuminates some of the issues between the Project and other organizations, this section will take a step back and examine the ideology underlying the Project's desire for independence and its efforts at coalition-building. In order to examine these issues, however, one must start with Byllye Avery and her long-standing relationships with white feminists.

In her early years as an activist in the late 1970s, Byllye Avery worked closely with white

women, both at the Gainesville Women's Health Center and Birthplace. As discussed in the first chapter, Avery's own political awakening occurred as she spoke to and worked alongside white feminists. In particular, white feminist concerns about health care and reproductive health struck a chord in Avery. This interest in women's health revealed to Avery a serious divide between white women and women of color. According to Avery,

I became interested in women's health. And the issues that I was interested in, the white women were the only ones talking about them. The black women weren't. But I was always trying to find [where] black women were, you know, and this woman is a nurse over here, could I talk to her, et cetera. . . I have to admit, during those times, I was avoided by a lot of black women, because they didn't know what they thought about these issues and they didn't want to talk about them.20

Black women's hesitance to speak with her, however, did not come from a lack of interest in the topics. Rather, as Avery argues, there was a stigma in the black community surrounding issues of reproductive health, especially abortion.21 Avery herself remembered that she worried what her mother might think after she began discussing abortion and reproductive health issues in the early 1970s. Although Avery found it fairly easy to speak about these issues with white women, extending this conversation to black women was often difficult.

20 Avery interview, 66.
22 Avery interview, 14-15.
However, Avery began to notice that, as she was more visible and vocal, black women began to approach her. “What I later learned is that [black women] admired me,” Avery remembered. “They were glad I was there, but they just didn't know what to do with me.”  

Slowly, more and more black women began speaking to Avery about health issues, opening doors to other women in black communities both in Gainesville (the home of the Gainesville Women's Health Center and Birthplace) and Atlanta (the home of the NBWHP). As Avery began working to develop the Black Women's Health Project under the auspices of the NWHN, she learned the skills to interact with the white members of the NWHN and the black women interested in attending the first conference on black women's health issues. According to Avery, she “learned how to move back and forth between the worlds” of white and black activists, a critical skill for an activist of color.

This ability to relate to both black and white activists served Avery well, and it supported her belief that, while black and white women often had different priorities, there was room for mutually beneficial relationships between activists of different races. After all, white women in the NWHN were critical in establishing the program for black women, and they funded most of the first conference on black women's health issues. However, tensions did blossom between the NWHN and those calling for the independence of the NBWHP, especially when Project leadership made it clear that white women would not be allowed to join the group. The NBWHP insisted they had the “right to restrict participation to Black women so that we may work toward defining and articulating our own authentic voice as a specific socio/economic group recognizing our historical place, our contemporary struggle, and our goals and dreams for the future.”

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23 Avery interview, 66.
Separation would be necessary in order for black women to find their voices and articulate their needs, especially since their priorities often differed from their white allies. Although many NWHN board members supported the fledgling NBWHP's calls for independence in 1983, as discussed in chapter one, NWHN president Sybil Shainwald fought the NBWHP's calls for independence. As an organization, the NWHN had emphasized the importance of organizing women of color, and actively sought out members of color. The Network was one of the only women's health groups with women of color on its board, and Shainwald felt that Project independence might detract from the Network's interracial organizing. “If I'd been at that [conference],” Shainwald argued, “that project would've never left us. [The Black Women's Health Project] was the most important thing we had.”

Shainwald feared that the legitimacy of the NWHN's interracial organizing might be lessened if women of color fled the organization in favor of working independently, a process which began when the NBWHP broke from the group. Despite these tensions, Project leaders, especially Avery and Lillie Allen, wanted to work with white women, but they wanted these interactions to be equal. In order to work with each other on an equal basis, however, white and black activists would have to bridge the boundaries between them. White women would have to learn to overcome, or at least understand, their own feelings about race, confronting their privileged positions in American society. As Winifred Breines notes in her examination of socialist feminists in the 1970s, black feminists “wanted white feminists to give up their privileged positions and perspectives,” to see things from black women's location. Black women “desperately wanted whites to understand their own complicity in racism and to reject it.”

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25 Avery interview 31.
feminists would be difficult if not impossible. Project leaders understood that dealing honestly with racism would not be an easy process, but the NBWHP insisted partnerships and alliances would not be possible unless women of different races came to a level of understanding about each other's historical positions. As Lynn Paltrow, founder of the National Advocates for Pregnant Women (NAPW) and a NBWHP white ally, noted, “you can’t sustain political movements if you don’t know who you’re marching next to.” The Project would have to develop some sort of program to facilitate understanding between activists of different races if they were to foster alliances between the two.

Given that the self-help process was the backbone of the NBWHP, it made sense to adapt this program in order to grapple with racial issues. After all, the process aided black women in overcoming internalized oppression, so it made sense to Project leaders that the process could aid white women in dealing with their own racial prejudices and feelings of guilt. The program, called “Sister and Allies,” brought together white and black women in order “to build trust to enable them to work together to build an inclusive movement.”

Many of the Project leaders, including Allen and Avery, had had positive experiences with white activists, and they believed the Women's Health Movement could be truly inclusive. Just as black women had to confront their internalized oppression, NBWHP members argued, white women had to confront their prejudices, their guilt, and their own privilege.

In order to facilitate alliances between black and white activists, the NBWHP courted both white activists and other women of color, urging them to attend “Sisters and Allies”

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28 Silliman, Undivided Rights, 71.
workshops. Activists from women's health and reproductive rights groups such as the Reproductive Rights National Network (R2N2), the NAPW, the National Latina Health Organization (NLHO), and the Native American Health Education Resource Center (NAHERC) traveled to Dahlonega, Georgia, a vacation destination in the North Georgia mountains and the home of most of the Project's early conferences and programs. It was here, in this “spectacularly beautiful” area that women's health activists began working through the issues dividing them.

Many of the activists attending the Project belonged to organizations which were struggling with racism in their own organizations. Some reproductive rights groups, such as R2N2, were consciously anti-racist, making the concerns of women of color a priority. R2N2, founded in 1979, was an umbrella organization comprised of a number of national and local groups all committed to women's reproductive freedom. R2N2 was an “eager ally” for women of color's organizations, and consciously courted activists of color, echoing “the critique of population control and 'choice' that had been articulated by women of color. It emphasized access to abortion services and funding, arguing that without access, abortion rights would not be realized for low-income women and women of color.”

Many R2N2 activists saw a clear connection between the struggles against racial and sexual oppression, and made the fight against racism, both within R2N2 and the larger reproductive rights movement, a priority.

Although R2N2 paid lip service to anti-racist work, the organization had a number of problems putting their anti-racist politics into practice. Inclusion was a major goal of the group,

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29 Unfortunately, it is difficult to figure out how many workshops or conferences the “Sisters and Allies” program hosted. There are not many sources available on the program, but those that are available suggest it was a long-term program, not a one time conference or workshop. The only specific date I find for a “Sisters and Allies” conference is November, 1989. Marlene Gerber Fried, “Acknowledgments” From Abortion to Reproductive Freedom: Transforming a Movement, ed. Marlene Gerber Fried (Boston: South End Press, 1990), vii.


31 Silliman, Undivided Rights, 33.
but even R2N2 leaders recognized the organization was “overwhelmingly white.” Fearing a split within the organization over race and racism, the group organized a series of conferences between 1981 and 1982 to address racial issues and decide how much of a priority the group would place on its anti-racist work. Although R2N2 members were well-intentioned in their attempts to make anti-racist work central to their mission, black women within R2N2 noted that white women within the group were “say[ing] they want to deal with racism, but [they] are not really willing to relinquish their power.” Part of the problem, according to activist and R2N2 leader Marlene Gerber Fried, was that white women were all but paralyzed by their own issues surrounding race and white privilege. “We knew that there was racial oppression,” Fried recalled in 2007. “We felt that by being white you were part of [the oppressing group], and so how do you deal with it? You just deny it. You know, you desperately try and find one of your other identities [to identify with].” Although R2N2 leaders were trying to deal with issues of race, their own paralysis and denial made serious changes nearly impossible. Rather than acknowledging privilege and racism in order to create a new kind of movement, the leaders simply tried to bring women of color into the group while ignoring potentially divisive racial problems. Desire to deal with racism and actually putting in the work to overcome these issues did not always go hand in hand. Although R2N2 members, such as Fried, genuinely wanted to find a way to work together with women of color, they did not necessarily have the tools to do so.

For white activists, including those who belonged to R2N2, the “Sisters and Allies” program of the NBWHP provided them with such tools. The program adapted the Project's self-

33 Quoted in Nelson, Women of Color, 170.
34 Fried interview, 69. Ultimately, R2N2 disbanded due to these conflicts over race. According to the authors of Undivided Rights, which included Fried, R2N2 “ultimately dissolved over disputes about whether to make fighting racism within the organization its top priority.” Silliman, Undivided Rights, 33.
help process in order to help white women and women of color begin to build trust within the movement. Given self-help’s importance in aiding black women in overcoming internalized oppression, it made sense to Project leaders that the same process might help white women deal with racial privilege. During a “Sisters and Allies” conference, white and black women (and women of other races and ethnicities who may have been in attendance) would gather together in a large group. Lillie Allen would discuss the self-help process and, as a large group, participants would begin discussing race and what it meant to them both personally and politically. The women would then be divided into smaller groups to continue using the self-help process. Each smaller group would be led by an NBWHP member who understood self-help and could teach white women, and other non-Project members, how to utilize the process.

This raises the question of what, exactly the NBWHP hoped white women would learn through the self-help process. In essence, the Project wanted white women to confront their own prejudices and racial privilege, as well as to learn about their own position in systems of oppression. As one can imagine, this process was difficult for white participants. As Fried recalled, her small group was racially diverse. When her group leader, activist Loretta Ross, asked the group how race and racism had been an issue in their own lives, Fried and the other white women began to feel uncomfortable since they were dealing with racism “from the side of privilege.” White participants felt guilty about their privileged position, and a number did not want to express their own feelings about race, fearing the reactions of women of color participating in the groups.

Ignoring or denying these complicated feelings about race would not help white women work in harmony with women of color. On the contrary, denial would only throw up roadblocks
to alliances and an inclusive movement. Through the “Sisters and Allies” program, white participants had to face their complicated relationships with race and racism. For a number of white activists, the program allowed them to begin the process of “de-centering whiteness and racism.” Even activists interested in anti-racist work tended to normalize white women's experiences and, when faced with demands that they face their racism, responded with paralyzing guilt or complete denial. Defensive responses to black women's attempts to confront white women on their racism would cause alliances between the activists to fall apart, NBWHP leaders believed. The “Sisters and Allies” conferences were an attempt to get white women to understand that white women's experiences were not universal, and to give them the space and the tools to “get over some of [their] personal crap about race.” It was not black women's responsibility to teach white women about racism, even though many white activists believed that black women needed to tell them about their mistakes. As black feminist and poet Audre Lorde described, “whenever the need. . . for communication arises, those who profit from our oppression call upon us to share out knowledge of them. In other words, it is the responsibility of the oppressed to teach the oppressors their mistakes.” Although Project leaders were willing to begin bridging the differences between black and white activists, they placed the burden of learning about, and dealing with, racism on the shoulders of white activists. The Project recognized that, just as it was difficult for black women to come to terms with their own internalized oppression, it would be difficult for white women to grapple with their own roles as oppressors. Thus, although they placed the burden of grappling with racism on white women, Project leaders did work to develop a program to help white activists face their guilt surrounding

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35 Fried interview, 76.
36 Ibid., 74.
Many white activists responded positively to the “Sisters and Allies” program. For Fried, the program taught her a lesson about white women's racial guilt. White guilt was white women's problem. “We're not here to fix this for you,” Fried recalled Ross telling the group. “We all come from a lot of whatever, and it doesn't mean you can't be a good ally and a good activist. That's the message: that you can have benefited from oppression, you can be a part of the oppressing race, and you can still do this work.”

Simply being white did not preclude productive relationships with activists of color. However, as Fried argued, “white women had to get over ourselves or get out.” In essence, the Project was urging white women not to make racism and their guilt the central subject of discussion between white and black activists. White women could take the self-help process and use it to deal with their feelings surrounding race, and this would free them to speak with black activists about mutual concerns. As Fried suggested, the conferences re-centered the conversations between black and white activists over an inclusive movement, rather than centering the discussion on racism and how white women had harmed women of color.

Although Fried responded positively to “Sisters and Allies,” others were not impressed with the self-help process which was sometimes seen as “too new-agey” or “kooky.” Some activists questioned if the process could even be seen as political. Although the process resembled consciousness-raising in a number of ways, some white activists did not agree that there were political implications of the self-help process. Additionally, others were turned off by Lillie Allen's approach in the large group meeting. Although the self-help process could be emotionally difficult, some women thought Allen took things too far. In describing the large

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38 Fried interview, 75-76.  

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group self-help session, Fried recalled

Lillie. . . would, you could say select, target somebody to be recipient of this [the self-help process]. It was pretty rough stuff. I mean, she used personal knowledge that she had of people. . . it was crossing a lot of lines. People would get extremely upset, and then other people would have, like, secondary upsetment [sic] from watching this. To me, those sessions were like, I think I almost just discounted them.

You know, I just tried to get out without getting harmed.40

Some women were clearly put off by Allen's style, which often crossed personal boundaries and veered into emotional manipulation, but the small group meetings really helped white activists begin the process of dealing with their complicated relationships to race and oppression.41

Understanding one's position as an oppressor was not easy, especially for activists dedicated to fighting against oppression, but facing this reality would be critical for women of different races to become allies. Unless white women could, as Loretta Ross argued, get over themselves, race would continue to be a divisive issue.

The NBWHP restricted membership to black women, but the organization did establish a committee made up of men and women, both black and white, who were sympathetic to the Project and its goals. The Council of Allies was a “national committee of supporters” which was “established to assist the organization in its growth and financial development as well as in

40 Fried interview, 75.
41 Both Loretta Ross and Byllye Avery describe some issues with the way Allen ran some self-help sessions in their oral histories. Fried's oral history suggests that the white participants were turned off by Allen's style, not necessarily the process itself. Fried, for example, was not impressed by Allen but enjoyed the small group session led by Ross. Fried interview, 75.
gaining national visibility." Members of the committee included NWHN director Belita Cowan, scholars affiliated with Spelman College, such as Dr. Virginia Davis-Floyd and lawyer Henri Norris, Lynn Paltrow, the president of the National Alliance for Pregnant Women, and Dr. Melanie Tervalon, a board member of the National Abortion Rights Action League (NARAL). The group served as a link between the NBWHP and community resources, and worked in their individual communities to help the Project establish a presence. This Council would allow non-black members to share ideas and resources with the Project while respecting the NBWHP's decision to restrict its membership to black women. The presence of the Council ensured that Project members and their allies could come together to discuss mutual priorities and to share resources where possible. Creating these alliances with activists in other organizations allowed interested parties to work with the Project to achieve their goals, making the Women's Health Movement more inclusive and responsive to the needs of various women.

Both the “Sisters and Allies” conferences and the Council of Allies created spaces for black and white women to build trust and learn how to work together despite their differences. Independence was necessary, in the eyes of Project leaders, because black women needed to work apart in order to learn how to overcome internalized oppression and to articulate their distinct needs and priorities. Working with other activists would be necessary, however, if the Project wanted to foster an inclusive and welcoming movement. Coalitions would be critical to achieve mutual goals, but white women had to face their own racism and come to terms with their guilt at being part of an oppressive system. Otherwise, relationships between women of

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color and their white allies would continue to be strained, tense, and unproductive. As Winifred Breines describes in her analysis of socialist feminism, the hard work of building coalitions “educated” both black and white activists “in the ways of race and racism, on the long path toward women's liberation and social justice for all.” Although not all white activists responded positively to the Project's attempts to bridge the differences between them, Project leaders continued to try working with white women and encourage them to aid in the building of an inclusive movement.

Coalitions of Women of Color

Although the alliances between Project leaders and white activists were important in shaping the Women's Health Movement and making it more inclusive, their relationships with other women of color were perhaps even more significant. Historians have generally focused on the interactions between white and black activists, but the relationships between different groups of women of color illuminate some of the important differences amongst women of color.

The NBWHP was the first group to split away from the Women's Health Movement, organizing around their racial differences. By the mid 1990s, Latina, Native American, and Asian women had all organized into separate organizations, pushing activists to recognize that there were also important differences between women of color. Language barriers, immigration issues, and indigenous rights were all unique health concerns most African American women did not share. Unfortunately, the splitting of feminists into groups by race (for example, white feminists and

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44 Breines, Trouble Between Us, 191.
45 Few historians have examined how black women and other women of color worked together to build alliances and coalitions. Benita Roth's Separate Roads to Feminism briefly discusses how women of color worked together, but the majority of analyses of women of color's activism examine each group separately. See Silliman, Undivided Rights; Nelson, Women of Color; Breines, Trouble Between Us; Valk, Radical Sisters; Sandra Morgen, Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990 (New Brunswick, NJ: Rutgers University Press, 2002).
feminists of color) tended to mean that women of color were seen as a monolithic group. Thus, after the founding of the NBWHP, the organization became the figurehead for women of color and their health concerns.

What was clear to the Project and other women of color, however, was that there were still important differences among them. Once again, organizing independently would allow other groups of women to articulate their own priorities. A number of other activists of color were involved in predominantly white health organizations, and the Project's independence inspired these activists to form their own organizations. As the vanguard for women of color in the Women's Health Movement, the Project became a model for other activists of color. Byllye Avery built relationships with potential leaders, and helped these activists find the funding and support they needed for their organizations. As women of color, they built a community dedicated to making the movement more inclusive; the leaders of these organizations consciously connected with other women of color, establishing a strong base of non-white activists. These groups, which included the National Latina Health Organization, the Native American Health Education Resource Center, and the National Asian Women's Health Organization, all saw the Project as a model for their organizations, adopting and adapting, although sometimes rejecting, the Project's self-help process and wholistic vision of health.

As early as the 1970s, black feminists were struggling with how to relate to other women of color. How were their struggles related? Were there enough similarities between women of color to make productive alliances and relationships possible? The Black Women's Alliance (BWA), an offshoot of the Student Non-Violent Coordinating Committee (SNCC) and one of the first consciously black feminist groups, quickly placed an emphasis on anti-imperialism,

connecting the struggle of African Americans in the United States to those fighting the forces of imperialism throughout the rest of the world. Founded in 1969, the BWA worked to address sexism within the Civil Rights Movement, especially within nationalist groups which, as many black women argued, upheld sexist gender roles and notions of women's place within the struggle for black liberation. When women involved in the Puerto Rican independence movement and the Puerto Rican Socialist Party asked to join the BWA, members had to come to an agreement: should women of color who were not of African descent be allowed to join the organization, or should the organization stress the importance of coalition-building with other independent organizations? Although a number of members favored working with other groups only on specific issues, an even larger group believed “the complexities of intersection oppressions [were] more resilient than the distinctions of the particular social groups.”47 Women of color, as the BWA noted, had to grapple with the problems of interlocking oppressions. Although their experiences were different, the presence of intersecting oppressions in their lives meant there were more similarities than differences between these groups of color. Once the group expressed its solidarity with Puerto Rican, Chicana, Native American, and Asian women in 1970, all in support of their anti-imperialist ideology, the BWA became the Third World Women's Alliance (TWWA), a group dedicated to fighting against exploitation of people of color throughout the world.

However, as Benita Roth notes in her analysis of black, Chicana, and white feminisms, the TWWA represented only a minority of feminists of color, at least through the 1970s.

According to Roth, “a joint movement of women of color was not envisioned early in most of Black feminist organizing. . . or in Chicana feminist organizing.”\(^{48}\) Roth attributes this reticence to the presence of nationalist groups; once nationalist groups began falling away and stopped competing for resources, a space developed for “multiracial feminist organizing.”\(^{49}\) By the early 1980s, it became easier for women of color to begin bridging these gaps. The publishing of *This Bridge Called My Back: Writings by Radical Women of Color*, edited by Cherríe Moraga and Gloria Anzaldúa in 1981, marked a new era in which various feminists of color began to analyze their similarities and differences. The collection was one of the first to combine writings from black, Latina, Native American, and Asian American women, suggesting there were similarities amongst women of color despite their obvious differences.\(^{50}\) Although the collection analyzed the ways in which relationships with white women were built on the backs of women of color, the anthology also showed that there were many similar priorities amongst feminists of color. *This Bridge Called My Back* helped reveal that feminists of color, despite their differences, did have a number of similar priorities. Although racially and ethnically distinct, women of color began trying to establish connections and alliances in order to make feminism more inclusive.

The NBWHP was one of the first feminist health organizations which worked to cross these bridges, exploring similarities and differences with other women of color. Although Avery's main priority was improving the health of black women, she was conscious of the ways in which race, gender, and class negatively affected the health of other women of color. For this reason, Avery encouraged other health activists of color to found their own organizations. One of the

\(^{48}\) Roth, *Separate Roads*, 207.
\(^{49}\) Ibid., 220. According to Roth, nationalist groups generally did not encourage multiracial organizing. Government suppression and competition for resources made potential coalitions difficult, if not impossible, to build. Once these groups began to fall apart, according to Roth, it was easier for feminists of color to bridge these gaps.
\(^{50}\) Breines, *Trouble Between Us*, 173-174; Roth, *Separate Roads*, 220.
first women to discuss the possibility of another health organization devoted to the health concerns of women of color was Chicana activist Luz Alvarez Martinez.

Alvarez Martinez was one of the founders of one of the first women's health groups to emerge after the NBWHP, the National Latina Health Organization (NLHO). Founded in 1986 by four first- and second-generation Latin American immigrants, Alvarez Martinez, Alicia Bejarano, Elisabeth Gastelumendi, and Paulita Ortiz, the NLHO consciously modeled itself off of the NBWHP. Although Bjarano, Gastelumendi, and Ortiz were co-founders of the NLHO, the organization owes a larger debt to Alvarez Martinez who worked to bring the women together in order to found the organization. Alvarez Martinez, inspired by Avery and the Project's self-help process, worked to develop an organization modeled off the NBWHP which was sensitive to the needs of Latina women.

Alvarez Martinez becoming involved in the Women's Health Movement between 1978 and 1980, after she joined a medic training course that was being offered by the Berkeley Women's Health Collective (BWHC), a Feminist Women's Health Center in Berkeley, California. Divorcing part way through the training, Alvarez Martinez dropped out of the course, but Julianne Brown, one of the few women of color involved with the BWHC, convinced Alvarez Martinez to join the board and work with her to form a satellite clinic devoted solely to women of color. It was soon after Alvarez Martinez became a board member that she met

51 In Spanish, NLHO leaders called the group the “Organización Nacional de la Salud de la Mujer Latina.”
52 In her oral history, Alvarez Martinez hints that she became involved with the Berkeley Women's Health Collective as early as 1978. However, in Sandra Morgen's interview with Alvarez Martinez, she stated she became involved with the group in 1980.
53 Luz Alvarez Martinez, interview by Loretta Ross. Transcript of video recording, December 6 and 7, 2004. Voices of Feminism Oral History Project, Sophia Smith Collection, 40. The satellite clinic, called the South Berkeley Women's Clinic, opened in August, 1982. It was only open one afternoon a week, but the BWHC considered the opening to be an important step toward appealing to women of color in Berkeley. Morgen, Into Our Own Hands, 84.
Byllye Avery.

In 1982, Avery traveled to the BWHC to discuss the upcoming conference on black women's health issues with the board. At the meeting, Avery described the importance of such a conference, stressing the fact that conference was organized for black women by black women. Alvarez Martinez knew almost immediately that she wanted to travel to Atlanta to attend the conference, despite the fact that she was Latina. Accompanied by a few other BWHC members, most of whom were women of color, Alvarez Martinez managed to scrape together enough money to make it to Atlanta.

Alvarez Martinez was in awe of the conference and its organizers. “It was amazing to see workshops facilitated by African American women,” Alvarez Martinez remembered. “women of color were doing everything.” Seeing a conference made up of almost solely women of color was particularly inspiring for Alvarez Martinez. Like Avery, Alvarez Martinez's own feminist awakening happened as she became involved in predominantly white women's organizations. She had little knowledge of or contact with Chicana feminists, so the conference was one of the first times she saw a gathering of women of color working toward a similar goal. The conference had “a tremendous effect on me,” Alvarez Martinez recalled, “just seeing Black women do what they had done. I had never seen women of color do anything like that. Sure it was happening all the time, but I had never experienced it.” Seeing black women organize themselves and developing a conference program which addressed black women's needs was

54 Quoted in Silliman, Undivided Rights, 242.
56 Quoted in Morgen, Into Our Own Hands, 56.
inspiring to Alvarez Martinez. The majority of Alvarez Martinez's experiences with feminism had been in predominantly white organizations, so seeing women of color develop an entire conference made up of mostly black women was a life-changing experience.

In particular, Alvarez Martinez was impressed by Lillie Allen's “Black and Female” workshop. Although she was allowed to attend the majority of the panels and programs, as a Latina, she was barred from the workshop. “Knowing that there was this workshop that Lillie Allen did that was just for black women” was “so powerful,” Alvarez Martinez noted. “They kept saying, this is just for us and nobody else can be there. Wow. You can do that. You can do that. And they did it. And it was powerful.”

Although she was not able to see the process herself, Alvarez Martinez heard so many participants discuss the self-help process that she approached Lillie Allen to ask her about her work. Allen recommended a few re-evaluation counselors, one of whom was Paulita Ortiz. The two women quickly connected and Alvarez Martinez began learning about the RC process.

The women connected with Alicia Bejarano, a Planned Parenthood employee, at an International Women's Day conference in 1986; Alvarez Martinez had put together a panel on women of color's health issues. Bejarano immediately came up to Alvarez Martinez and Ortiz and, in Spanish, told the women that Latina women should form a group to talk about their own health issues. A light bulb went off in Alvarez Martinez's head; she had the NBWHP as a model and the women discussed how the Project's vision of an independent women's health group could be adapted for Latina women. Once the group decided they should form an independent organization, Alvarez Martinez approached Avery with the plans for a National Latina Health

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57 Alvarez Martinez interview, 42.
58 Ibid., 52; Silliman, Undivided Rights, 242-243; Morgen, Into Our Own Hands, 56.
Organization modeled off the Project. Soon after, Alvarez Martinez received a call from the Ruth Mott Foundation which was interested in funding the group. Avery had contacted the foundation directly and asked them to contact Alvarez Martinez to figure out funding. Alvarez Martinez attributes the early success of the NLHO almost completely to Avery. Avery had done the work of finding a funder. “That's the kind of support we got,” Alvarez Martinez recalled. “[Avery] sent a funder to us. And I know that's not something that's always . . . done, because there's such competition around [funding].” Avery, however, believed in the NLHO and believed in the presence of an independent group dedicated to the health of Latina women.

Avery's and the Project's influence did not end there, however. Oriz's experiences with RC and Alvarez Martinez's experiences with the Project's self-help process convinced them that the NLHO would have to adopt a similar process to empower their members. Self-help would be used as a “technique for transforming internalized oppression into action for social change,” just as it was used by the Project. When Latinas were empowered through the self-help process, they would be able to take control over their health and their healthcare. As the NLHO's founders argued, “the NLHO promotes Self-Help methods and self-empowerment processes as a vehicle for taking greater control of our health practices and lifestyles.” For the NLHO, just as for the Project, self-help had become the backbone of the organization.

According to Alvarez Martinez and Ortiz, the self-help process was critical for Latinas who were facing health problems which were similar to those faced by black women. As the NLHO founders noted, Latina women suffered from high rates of high blood pressure, heart conditions, addiction problems, and mental health issues. Social issues, such as poverty, also

60 Alvarez Martinez interview, 58-59.
61 Silliman, Undivided Rights, 243.
negatively affected Latina's health.\textsuperscript{62} Given the Project's successes with the self-help process, it only made sense that Latinas, who were facing similar issues, would benefit from self-help. The NLHO also looked to the NBWHP as a model when they began working on how to publicize the group and bring more women into the organization. Given that the Project brought black women together through a national conference, the NLHO envisioned a similar conference. Hosted in 1988, the conference brought together over 350 Latinas from across the country to discuss Latina health issues. Recognizing the language barriers some Latinas faced, every workshop and panel were translated into both English and Spanish, depending on the native language of the speaker. The conference addressed a number of issues including teenage pregnancy, drug abuse, AIDS, nutritional issues in Latino communities, job safety in agricultural industries, and the importance of \textit{curanderas}, \textit{parteras}, and \textit{hierberos} in Latin American culture.\textsuperscript{63} Additionally, the conference introduced participants to the self-help process and, in a similar fashion to Allen's "Black and Female" workshop, participants were encouraged to explore their lives and discuss how the information they gained at the conference could impact their lives and their health.\textsuperscript{64}

Although the NLHO was so similar to the NBWHP in a number of important ways, it was still critical to Alvarez Martinez, and to Avery, that the organization form independently from other health organizations, even the NBWHP. Latina women had health issues that were distinct from other women of color, even though they were also experiencing the problems associated with interlocking oppressions. Language barriers to health care, the problems faced by immigrants and undocumented residents, and the difficulty involved in organizing women from a

\textsuperscript{62} Silliman, \textit{Undivided Rights.}, 246.
\textsuperscript{63} Ibid., 249. \textit{Curanderas} are traditional or folk healers, \textit{parteras} are midwives, and \textit{hierberos} are herbalists.
\textsuperscript{64} Ibid., 249-250; Alvarez Martinez interview, 61-62.
wide variety of cultures and nations, were all issues that the NBWHP did not prioritize given the communities with which the Project worked.\(^{65}\) This, in essence, was why women of color needed to organize independently. As Avery noted, asking "what's the difference between black women's health issues, white women's health issues, Native American women's health issues, [and] Latina women's health issues" was one of the most important things she did as an activist.\(^{66}\) Just as white women could not define black women's health issues, the Project could not define the health issues of other women of color.

The NLHO was one of the first groups inspired by and modeled after the NBWHP, but it was not the only organization that could point to the Project as a source of inspiration. The Native American Women's Health Education Resource Center (NAWHERC), established in 1988, was the brainchild of Native American activist Charon Asetoyer. A dedicated health activist, Asetoyer worked for the American Indian Health Clinic, a health center in San Francisco established to provide services to Native Americans. She also served on the board of the Health Program for Women of All Red Nations (WARN), an organization founded in 1974 which dedicated itself to a number of Native American civil rights issues. Asetoyer became more directly involved in women's health issues in 1985 when she and her husband, Clarence Rockboy, founded the Native American Community Board (NACB) on Rockboy's Yankton Sioux Reservation in Lake Andes, South Dakota.\(^{67}\) It was here, on the Yankton Sioux Reservation, that Asetoyer and her husband founded the NAWHERC in 1988.

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\(^{65}\) The NLHO founders reflected the cultural and national diversity within the organization. Alvarez Martinez was a first generation Mexican immigrant while Ortiz was a second generation Mexican American. Bejarano immigrated from Ecuador as an adult, and Gatelumendi immigrated from Peru when she was an adult. Morgen, *Into Our Own Hands*, 57.

\(^{66}\) Avery interview, 45.

Asetoyer, who became interested in women's health issues through her work with American Indian Health Clinic, began conceptualizing a kind of center that could address the needs of Native American women. As a founder of the fledgling Native American Community Board, Asetoyer began reaching out to other women's health activists and began attending meetings and conferences in the hopes of making connections and learning more about what other activists were doing in their communities. It was through these conferences that Asetoyer met Avery and Alvarez Martinez, both of whom were interested in Asetoyer's thoughts about forming a Native American women's health center. Avery invited Asetoyer to tour the Project's headquarters which were housed in a residential home that Project workers dubbed the “Mother House.” According to Asetoyer, the Project's home felt warm and comforting, and she began conceptualizing a Native American women's health center which would also be located in a residential home. “It just seemed like a logical kind of setting for women and children,” Asetoyer believed.68

It was these relationships the Asetoyer began to build with Avery and Alvarez Martinez that helped Asetoyer find the support to build such a center. At a 1988 NWHN conference, Asetoyer described the goal of purchasing an inexpensive home to house the NAWHERC to Alvarez Martinez who urged Asetoyer to ask conference participants for money. Alvarez Martinez continued trying to get Asetoyer to describe the center, despite Asetoyer's embarrassment. Avery immediately wrote out a check for approximately one hundred dollars and challenged others to follow suit. By the end of lunch, Asetoyer had raised almost enough to purchase the home.69 A final grant from the Jessi Smith Noyes Foundation enabled Asetoyer to

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68 Asetoyer interview, 29.
69 Ibid., 30.
purchase a home to house the NAWHERC.  

With the financial support of a number of women's health groups and activists, such as Byllye Avery and the NWHN, Asetoyer was able to realize her vision of a center which would provide much needed health and social services to Native American women in the Lake Andes region of South Dakota.

For the NAWHERC and Asetoyer, support from Avery and Alvarez Martinez, both financial and moral, was far more important than the adoption of the NBWHP's self-help program. According to Asetoyer, the Project's self-help model would not have worked for Native American women. Rather, she looked toward traditional tribal talking circles and healing ceremonies, which she felt would appeal to Native American women interested in connecting with their tribal roots.

More than anything else, Asetoyer was inspired by the independence of the Project, and the group's attempts to build relationships with other women of color interested in women's health issues. Asetoyer, who joined the board of the NWHN in 1988, was impressed with Avery's insistence that women of color had agendas that were distinct from the mainstream white women's organizations. Before Avery broke the Project away from the NWHN, a number of white women's health organizations were trying to reach out to women of color. According to Asetoyer, “until Byllye Avery appeared on the scene, [white women's groups] were really, you know, trying to organize, or trying to address some of the women of color doing programming,

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70 Asetoyer interview, 30. The Jessie Smith Noyes Foundation was established by real estate tycoon Charles F. Noyes in 1947 as a memorial to his late wife, Jessie. Until 1985, the foundation was particularly interested in providing grants to groups aiding minority students. In 1985, the foundation rewrote their guidelines, stressing the importance of the environment and quality of life issues for minority populations. As the foundation noted, they “sharpened our program to focus specifically on sustainable agriculture, toxics [sic], reproductive rights, and environmental justice in the United States.” “A Brief History,” The Jessie Smith Noyes Foundation, http://www.noyes.org/taxonomy/term/15.

71 Asetoyer interview, 61. As the writers of *Undivided Rights* note, however, these roundtables were more similar to self-help than Asetoyer admitted. According to the authors, in these ceremonies, participants are encouraged to verbalize their person, social, and historical realities and to identify crucial issues relating to the specific topic being addressed. This space enables participants to deal with internalized oppression.” Silliman, *Undivided Rights*, 148.
and it's really not appropriate. It really needs to be done for and by us, you know, for and by women of color." Although many women's health groups paid lip service to inclusion, few were really able to adapt. The Project's independence inspired other women of color, including Alvarez Martinez and Asetoyer, to form their own organizations, groups which would be able to address their unique needs and priorities without having to be courted by white women's organizations.

Mary Chung, the founder of the National Asian Women's Health Organization (NAWHO), an organization founded in 1993, also pointed to the Project and Avery as an inspiration for organizing. Although Chung, like Asetoyer, was not necessarily interested in the Project's self-help process, she was influenced by the NBWHP's calls for independence and movement inclusion. As an activists, Chung was heavily involved in Asian Pacific Islanders for Reproductive Health, a reproductive rights group which worked closely with activists including Avery, Alvarez Martinez, and Asetoyer. Although reproductive health issues were important to Chung, she envisioned a health organization that would address the myriad health concerns facing Asian American women. Only twenty-six when she founded the organization, Chung pointed to Avery as an inspiration for independent organizing, and she credited the NBWHP, the NLHO, and the NAWHERC as responsible for creating an environment in which the NAWHO could exist. As Chung noted, “I was very lucky to have . . . Bylye Avery, Luz [Alvarez Martinez], and these other women” who “started to talk to the mainstream organizations and started demanding a seat at the table. So that work had been done and so by the time I started

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72 Asetoyer interview, 40.
73 For more information on the NAWHO, see Silliman, Undivided Rights, chapter 11.
74 Mary Chung Hayashi, interview by Loretta Ross. Transcript of video recording, December 15, 2006. Voices of Feminism Oral History Project, Sophia Smith Collection, 9-10. Chung later married, changing her name to Hayashi. To avoid confusion, I will continue referring to Chung Hayashi by her maiden name, Chung.
Although the NAWHO did not adopt the Project's program model, Chung herself argued that the NAWHO would not have existed, or at least would not have been as respected, had it not been for the hard work of women like Avery who paved the way for independent health activism amongst women of color. The Project was the vanguard in the Women's Health Movement, providing an organizing model for other women of color interested in organizing around their unique health concerns.

Additionally, as Asetoyer noted, Avery was responsible for helping to establish a network of organizations devoted to specific needs of women of color, a network which filled “an obvious void.” According to Asetoyer,

> some of the motivation for starting our own groups is because there were these mainstream issues, but the agenda was just very narrow and was not broad enough to include our issues. And so, we became very aware [after the founding of the Project] that we needed our own organizations, so that we could broaden the agenda, we could work on our issues, as well as the mainstream issues that affected us.\(^76\)

For Asetoyer, as well as Avery and Alvarez Martinez, independence meant that they could push the movement towards being more inclusive. Courting women of color and urging them to join white women's organizations would not make the movement more inclusive. Rather, this would further marginalize women of color. Although white activists were generally well-meaning, they

\(^{75}\) Chung Hayashi interview, 14.  
\(^{76}\) Asetoyer interview, 38.
did not always take the concerns of women of color to heart, adapting their agenda in order to meet the needs of black, Latina, and Native American women. In her discussion of the NWHN, Asetoyer noted that the group did not appreciate the program ideas of women of color. They were more interested in keeping focused on their agenda, and they did not want to see women of color challenge them on their priorities. “I knew they, [the NWHN], were not willing to broaden the agenda,” Asetoyer remembered.77 Alvarez Martinez echoed Asetoyer when she noted that mainstream white women's organizations were far more interested in wooing women of color in order to legitimize their programs than they were in developing an inclusive movement.

“Sometimes I would be the only Latina” at conferences and meetings hosted by white women's groups, Alvarez Martinez remembered. “At other times, I was the only woman of color” at these events.78

In response, activists of color banded together, sometimes pushing themselves into meetings, conferences, and gatherings hosted by white women's groups. As Alvarez Martinez noted, when an organization would ask an individual activist of color to attend a meeting or speak at an event, that woman would try and bring other women of color with her. For example, when Alvarez Martinez was invited to speak at a number of events, she would ask planners if she was the only woman of color speaking. If she was, she would start giving the organizers names of other activists, encouraging them to invite other activists. “Other women of color were doing the same thing,” Alvarez Martinez remembered. “We were opening doors for each other, to make sure there would be representation. And it was working. . . sometimes, the organizers would say, []Well, at this time it's not the right time.['] But either way, if I was invited, and I wasn't able to

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77 Asetoyer interview, 41.
78 Alvarez Martinez interview, 67.
bring other women with me, then at the event, I would make an issue of it . . . why aren't these other women here?" For Avery, this was possibly the most important thing she had done as an activist working with other women of color; she had fostered a supportive community of activists of color who, although working independently, were supportive of each other. According to Avery, the Project “created not only a place for black women to come and talk about their issues, but we were able to pass [that sense of community] along to sisters of color.”

As an organization, the NBWHP became a model for other women of color interested in organizing independently. The founding of the NLHO, the NAWHERC, and the NAWHO in the ten years after the NBWHP became independent was not a coincidence. These groups and their leaders all pointed to Avery and the Project as a model for organizing. Although only some groups, such as the NLHO, adopted the Project's self-help process, all of these organizations saw the Project as a model and a vanguard in the Women's Health Movement. As these groups understood, organizing independently was the key to making the movement more inclusive. Although well-meaning, few white women's organizations were truly committed to changing their agenda to include issues important to women of color. Thus, independence became necessary for changes in the movement. Separation, as these groups show, did not preclude alliances and relationships with white women's groups and each other. Rather, separation allowed women of color to build a community supportive of difference. Although its self-help process and its wholistic vision of health were important legacies of the Project, its efforts to build an inclusive movement were even more important and long lasting. After all, some organizations, like the NAWHERC, did not adopt self-help. However, they still pointed to the Project as an

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79 Alvarez Martinez interview, 68.
80 Avery interview, 40.
inspiration for their own independence. The explosion of health organizations devoted to women of color happened because Avery was willing to break away from the NWHN and demand a seat at the table for activists of color. Although the founding of these groups of color did not ultimately lead to a fully inclusive movement, the presence of the NBWHP, NLHO, NAWHERC, and NAWHO meant that white groups could not ignore the concerns of women of color. As the 1992 March for Women's Lives shows, predominantly white groups like NOW had to address issues of race and inclusiveness once women of color began working on their own health issues, both together and apart.
Epilogue
The Magic Was Not There: Byllye Avery and the End of the NBWHP

“The first five years of the [National] Black Women's Health Project were absolute bliss,” Byllye Avery recalled in 2005. “We were on an upward curve. We were attracting everything. We were attracting women. We were attracting funding. We were attracting people around us.”

Avery and the other NBWHP leaders were thrilled with the rapid growth of the Project during its formative years. However, their excitement was quickly tempered by some of the harsher realities of organizing. For the Project, 1989 was a turning point. A flurry of de-stabilizing events occurred within a short period of time, events which would forever change the structure and make-up of the NBWHP. Major leadership changes, shifts in guiding philosophy, and a physical shift to Washington all led to a long period of change for the organization. By 2002, the Project had abandoned grassroots organizing, its self-help process, and its name. Renamed the Black Women's Health Imperative, the group was no longer recognizable to its founder Byllye Avery. For Avery, the magic of the Project's early years had completely disappeared.

As noted earlier, between 1984 and 1989, the Project saw their numbers climb quickly, partially in response to the increase visibility of the NBWHP. The rise in membership was amazing, but that growth was “explosive but unregulated, unorganized.” As activist and NBWHP Program Director Loretta Ross noted, Avery had a strong presence in the media. As the Project became more famous, large numbers of women began calling the Project's offices in Atlanta asking how they could join the organization. Additionally, groups were calling themselves Project chapters even though they had no affiliation with the NBWHP, and many of

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those groups knew nothing about the self-help process. Part of the problem, according to Ross, was that the Project did not have a clear infrastructure and really had no guidelines concerning chapters or self-help groups. Avery had little experience, or interest, in management, and the Project's lack of infrastructure can be largely attributed to Avery's inability, or disinterest, in doing the hard work of setting up a clear structure for the group.\(^3\) Ross was hired and tasked with developing a structure for the organization, a job she took seriously. Quickly, Ross began writing guidelines for the chapters and began developing a self-help manual which would facilitate the spread of self-help.

Avery's lack of management experience fed into the growing tension between Avery and Lillie Allen which had reached a boiling point by 1989. As originally conceived, Avery's job was to deal with the day-to-day management of the Project, and Allen's task was to keep the Project “rolling and growing through Self-Help.”\(^4\) In essence, although the Project was Avery's child, both Allen and Avery were supposed to share the responsibility for the success of the NBWHP. As the years pushed on, their relationship became more strained and competitive as the two women appeared to battle for control of the Project. Allen accused Avery of trying to oust her from the NBWHP in front of a large audience and Project staff during a self-help session at a NBWHP retreat. Described as “traumatic,” this session forced staff to begin questioning who was truly in charge of the Project. As Ross remembered, Project staff began wondering “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?”\(^5\) The conflict between the two women made many staff members feel like the mothers of their organization

\(3\) Ross interview, 208; Avery interview, 41.
\(4\) Ross interview, 208.
\(5\) Ibid., 209.
were divorcing, so contentious Avery's and Allen's relationship had become.

These feelings were only exacerbated when Avery won a MacArthur Foundation award in 1989. Nicknamed the “genius grant,” the MacArthur grants were awarded to activists working to create a more just and equitable society.\(^6\) Avery won the award based on her activity with the Project, fanning the flames of jealousy amongst some Project staff including Allen. “I was getting awards, and I always tried to be inclusive and say that it was not my work alone, it was the work of many women who worked in the Project,” Avery insisted.\(^7\) However, once Avery received the MacArthur award, the media increasingly began conflating Avery and the Project. Although Allen was responsible for developing one of the guiding programs for the NBWHP, Avery earned the acclaim, and significant monetary benefit, for the NBWHP.

After she received the MacArthur award, Avery also decided that it was time to take a step back from the Project, handing the reins over to another woman. In part, her decision was based on the Project's Board which demanded that she either take classes to learn about management, or support the Board's decision to hire an official executive director. Avery told the board they should hire an executive director, and Avery transitioned to a new position, the Founding President. By 1989, Avery was simply exhausted. The constant travel, the stress from the problems between she and Allen, and stress of heading a growing organization all took a toll on Avery who used money from the MacArthur grant to take some time to rest and do some travel for leisure instead of for the Project.

Avery's decision to step down as director also followed Allen's own exit from the

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\(^6\) According to the MacArthur Foundation's website, they awarded the fellowships to “talented individuals who have shown extraordinary originality and dedication in their creative pursuits and a marked capacity for self-direction.” The grants, totaling $500,000 each, were awarded to individuals with no strings attached. [http://www.macfound.org/pages/about-macarthur-fellows-program/](http://www.macfound.org/pages/about-macarthur-fellows-program/)

\(^7\) Avery interview, 40.
organization. The causes for Allen's leaving are complicated and a bit opaque. In Allen's eyes, Avery began turning her back on the self-help process by 1989. In an interview Ross conducted with Allen in 2003, Allen believed her relationship with Avery collapsed when Avery began to opt out of staff self-help sessions as a way of avoiding being held accountable for the serious structural problems facing the Project. Avery also supported other staff members' decision not to be involved in self-help sessions, which angered Allen. How could the staff of an organization based on self-help opt out of that process? However, according to Avery, she distanced herself from staff self-help sessions because the confidentiality of the sessions were not being respected. According to Ross, issues that Avery revealed during self-help sessions were used against her during the dispute between Avery and Allen. Avery continued to believe in the self-help process; she simply feared that anything she disclosed could be used against her at a later time. As Avery and other staff members began opting out of the self-help process, the divide between Allen and Avery deepened, becoming more contentious and more personal. Increasingly, staff members began questioning the importance of the self-help process. It was a way to bring in more members, but a large segment of the staff did not see it as integral to the NBWHP's vision.

The disagreement between the two women led to a “vision crisis” within the group. This crisis centered on what should be the NBHWP's “strategic focus-building grassroots Self-Help chapters across the country or influencing public policy.”

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9 Ibid. 222.
10 In her oral history, Loretta Ross describes how Allen and Avery began competing with each other on a personal level, which only made their professional problems worse. Additionally, according to Ross, Allen became more “cultish” which turned off a number of Project staff members. The staff was split between Allen and Avery supporters. The tensions between the two factions got physical, according to Ross who remembered that there were physical fights between staff members and that one staffer even pulled a gun and left it on her desk “to let people know not to fuck with her.” Ross interview, 210-211. Since I've not been able to find any other source discussing physical violence within the Project, I opted to include this information in only a footnote.
as the staff worked to figure out where the Project's priorities lay. Ultimately, the staff and board decided that the self-help model was “no longer central to [the] NBWHP's mission.”12 Once the decision was made, Allen left the NBWHP to found another organization, Be Present, which was a center designed to continue spreading the self-help process that Allen had developed during her time at the Project. The split which had begun the year before was complete. Allen was no longer affiliated with the Project and Avery had transitioned into a new position within the group, although she remained close to the organization.

The changes did not stop there, however. In 1990, the Project opened a policy-based office in Washington, D.C. headed by Julia Scott. The Project's base would remain in Atlanta, but Project leaders believed they needed a presence in Washington if they were to have any hope of bringing about real political change. The opening of the office signaled that the Project was transitioning from a grassroots, self-help organization to a more policy oriented organization like the National Women's Health Network. Scott set up a Public Policy and Education Program (PPEP) once she arrived in Washington which was tasked with promoting “a broad range of public policies to improve black women's health.”13 The PPEP researched black women's health issues, developed educational resources, sent out legislative updates on legislation important to black women, and coordinated “calls for action” on health issues facing black women. The establishment of the PPEP was an obvious sign that the Project wanted to establish itself as “a player in mainstream politics.”14 Although self-help had not completely disappeared from the group by 1990, the establishment of the public policy office in Washington signaled the slow collapse of the Project's grassroots programs.

12 Silliman, Undivided Rights, 76.
13 Ibid., 77.
14 Ibid.
This shift is a critical one in the history of the Project. Although the disagreement between Avery and Allen was certainly one of the causes for the abandonment of self-help, it does not account for some of the more practical reasons the Project began moving away from self-help. By 1989/90, the Project was in financial straits. Budget constraints had led to a purge of Project staff between 1989 and 1990, and the situation did not appear to be improving. The NBWHP received the majority of its funding from private donors and foundations, many of whom wanted to see how, exactly, their money helped black women and their families. The difficult work of organizing self-help groups and enabling black women to overcome internalized oppression “did not lend itself to easy measurement” and did not “have clear policy outcomes.” The Project increasingly had a difficult time raising money for their self-help program, which was rather expensive work, and it seemed more practical to try and raise money to fund the PPEP which was more foundation friendly. The financial realities of supporting a large, grassroots organization began to wear on Project leaders.

Between 1991 and 1996, the Project's priorities began shifting more clearly toward the Washington policy office. The PPEP was able to raise enough money to support its work, but the Project could not continue supporting the office in Atlanta. In 1996, director Julia Scott closed the Atlanta office, laid off the entire Atlanta staff, and moved the main office to Washington, D.C. Grassroots organizing was all but abandoned once the Project moved to Washington. The organization became even more recognizable when Scott resigned in 2001 and the board hired Dr. Lorraine Cole as the executive director. Cole almost immediately laid off the majority of the

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15 Silliman, Undivided Rights, 76.
16 Avery interview, 42. Although funding threw the NBWHP into crisis in 1989/90, Avery had difficulty raising money for self-help groups from the beginning. According to Avery, “funders were saying to me, [‘]Why do I have to give you money to keep doing Self-Help[?]’” Avery interview, 33.
staff and, within a year, renamed the Project the Black Women's Health Imperative. By 2002, the NBWHP had officially disappeared, evolving into an almost unrecognizable organization.

The collapse of the NBWHP was an extremely painful process for Avery. As the founder and the architect of the organization, watching the Project abandon self-help, move to Washington, and change its name was difficult. As Avery recalled. “I watched [the NBWHP] slowly evolve. . . there was this move to change the name of the organization. . . it broke my heart and I was just so upset.” The organization that Avery had devoted her life to had morphed into a wholly different group. “The organization had started a decline, and we were never able to get back up to the pitch of where we were in the '80s. We just never were able to get there.” Avery attributed the loss of the Project's magic primarily to its abandonment of self-help. “I felt the organization was the Self-Help part,” Avery insisted. Although the Project continued to do some good work after it moved away from self-help, “the magic was not there.”

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17 Silliman, *Undivided Rights*, 77-79. According to Ross, Cole was consciously trying to distance herself from Avery's vision because she was intimidated by Avery's “shadow.” Ross interview, 221.
18 Avery interview, 43.
19 Ibid., 42-43.
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