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Lessons in Community Health Activism:

The Maternity Care Coalition, 1970–1990

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Abstract

This study employed historical methodologies to explore the means through which the Maternity Care Coalition used grassroots activism to dismantle the power structures and other obstacles that contributed to high infant mortality rates in Philadelphia's health districts 5 and 6 during the 1980s. Infant mortality within the black community has been a persistent phenomenon in the United States. Refusing to accept poverty as a major determinant of infant mortality within marginalized populations of women, activists during the 1980s harnessed momentum from a postcivil rights context and sought alternative methods toward change and improvement of infant mortality rates.

Keywords

activism; collaboration; infant mortality

In the 1980s, the City of Brotherly Love had some of the nation's worst outcomes in terms of infant mortality. Infants in Philadelphia Census Tract 152 were dying at the rate of 34.7 per 1000, which was almost 3 times the national rate (12.5%) at the time (see Table 1). An article that appeared in the *Philadelphia Inquirer* on April 5, 1982, was titled as "5 Blocks That Offer Slimmest Hope to a Baby,"¹ The article shared the grim story of a city whose lack of prenatal care options for marginalized women in combination with the city's poor coordination and delivery of health services contributed to the growing phenomena of poor maternal-child outcomes. It was not until a small group of social justice activists came together to address the issue that the long process to create social change began. The group was known as the Maternity Care Coalition (MCC), and this article examines the organization's history. The study of family and community health through a historical lens provides powerful insights into problems that continue to exist today, History allows us to look back, consider how a community's sociopolitical context affected their health, and ultimately develop strategies for the present on the basis of our lessons from the past.

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METHODS

Historical methods were used to identify appropriate sources and evaluate and interpret data from these sources within the broader framework of historiographical literature. In addition, a social history framework, with case studies and oral histories, was employed to describe and evaluate the players involved in the MCC. Ten oral history interviews were conducted with various participants of the MCC. Approval of institutional review board was obtained for this study.

Primary sources included documents, notes, personal letters, and other archival sources in 3 university archives. Secondary sources included a large body of scholarship on the civil rights movement, the feminist movement, the women's health movement, and scholarship considering health care as a civil right.

Social justice, grassroots advocacy, and the MCC, 1970–1990

Examining maternal child health care in Philadelphia during the 1980s requires situating it within a local and national context. Philadelphia in the 1980s was an urban representation of intersecting coalitions, voices, and calls to action. Women's health advocates called for equality, democracy, and the right to claim ownership of their bodies, their health, and its management. Yet, despite this passionate call to sisterhood, the women's health movement struggled with the messy multiplicity of women's voices. Minority women criticized the leaders of the national women's health movement for neither hearing nor acting upon minority and marginalized women's unique concerns and numerous accounts of injustices. Indeed, the distinctive decade of the 1970s ushered in a complex 1980s landscape. Social movements for racial justice, environmental justice, and an end to the war in Vietnam intersected with women's, Black Power, and anti-imperialism movements.² In addition, a prospering political New Right provided "push back" to the activist groups.

The sociopolitical context in 1980's Philadelphia included tragically high infant mortality rates, a growing Black Power presence, as well as a growing mistrust from minorities toward medical institutions. Philadelphia's black communities struggled with the closure of its own Philadelphia General Hospital (PGH) as well as the increasingly contentious relationship with its law enforcement agencies and city leadership. For this historical account, I locate the problem of Philadelphia's tragic infant mortality within this context. Next, I introduce Philadelphia's problem of maternal-child health followed by a look at its black community, and the beginnings of the MCC. Finally, I discuss the lessons of this era for the present.

Infant mortality in Philadelphia in the 1980s

In January of 1982, the National Health Law Program initiated the Maternity Care/Infant Mortality Project devoted to the work related to maternity care for the poor. This project was started because of increasing problems faced by low-income clients in accessing maternity care services, both health services and other support services necessary to ensure positive pregnancy outcomes. Over the course of the project, the National Health Law Program heard

countless accounts of low-income women denied access into hospitals while in labor as well as a growing number of physicians refusing to accept Medicaid coverage.³

In the 1980s, certain geographical areas had national infant mortality rates higher than in some Third World Countries. As Professor Edward Sparer of the University of Pennsylvania School of Law described, "... the definition of this death gap is the difference in infant deaths between babies of the have and babies of the have-nots."^{3(p13)} This national problem was also occurring in Philadelphia. Pregnant women on Medicaid, the uninsured, undocumented immigrants, drug addicts, and prisoners were representative of those who encountered great difficulty in obtaining prenatal care in 1980s Philadelphia. Not surprisingly, it was these women whose infants were being born prematurely and/or dying at tragically high rates. Those outcomes affected both the mothers as well as the cities whose hospital systems then worked to care for these infants. Hospital costs per premature infant in the 1980s averaged \$79418 while the cost for every 100 women denied prenatal care cost \$397090 in avoidable neonatal intensive care charges.^{3(p15)}

The question became, why were these outcomes happening in Philadelphia when the city boasted of having 5 major university-affiliated hospitals with residency training programs? In addition, 4 of these hospitals had contracts with the City of Philadelphia and the Maternal Infant Care Program to provide obstetrical services to the communities they served. Many believed the answers were buried in issues of race, class, and gender.

The Philadelphia black community in the 1970s and 1980s

As black women contended with growing rates of infant mortality in 1970's Philadelphia, black political and community activists were assembling over issues of political representation in their communities as well as health care delivery. Struggles regarding the PGH were included on their agendas.⁴ Situated as a hospital that cared for the indigent; PGH was the center of a contentious battle to close its operation in February 1976. Philadelphia Mayor Frank Rizzo, who was viewed suspiciously by many in the black community, faced massive criticism for his final decision to permanently close PGH's doors. Echoing the sentiment of many in the black community, Dr Austen Sumner, a member of PGH's medical staff, went on record with a statement that included, "Our patients cannot be cared for elsewhere, and we believe that they will suffer if PGH closes."^{4(p68)}

Philadelphia General Hospital was consistently surrounded by rumors of patient neglect and substandard care. In one such case, a *Daily News* reporter Hoag Levins submitted a scathing report detailing the hospital and its care. Posing as an ailing homeless patient, Levins was admitted to the hospital where he described the "... less-than-humane care..." by staff and deplorable patient conditions.^{4(p69)} Despite the accounts of substandard care, there were many in the black community who strongly supported PGH. To them, PGH represented a hospital that took care of its own with a medical staff comprising both white and black nurses and doctors. The black community felt safe within the walls of this hospital. Yet, in other Philadelphia hospitals, minority women were not experiencing that feeling of safety. As a result, some activist minority women began their grassroots organizing.

Black economic development conference and Triple Jeopardy

Within the political unrest surrounding 1970's Philadelphia, black grassroots organizations grew in number and political strength. The National Black Economic Development Conference (BEDC) was one example. Constructed as a movement to bring reparations to the black community for the alleged participation or complicity of groups in institutional arrangements that had disadvantaged African-Americans over the years, BEDC also held an office in Philadelphia. Cynthia Waters, current Director of Program Operations and Community Development of the MCC, was a member of the Philadelphia chapter of BEDC (C. Waters, oral history interview, September 2012).

Waters went on to form Triple Jeopardy as a coalition within the local BEDC. Waters came from several generations of black feminist thought and social activism. Triple Jeopardy was representative of rising black women's feminist ideologies during the 1970s. As such, it was an example of one of many organized collectives by minority women that resulted from the oversight by the national women's movement to address poor and minority women's concerns and issues. Initiated in 1972, Triple Jeopardy became one of Philadelphia's first organized black feminist support coalitions. Triple Jeopardy was inspired by the Relf Sisters' sterilization abuse case in Alabama in which the US Office of Economic Opportunity's family planning program in Montgomery, Alabama, conducted unethical medical experimentation on sisters Mary Alice and Minnie Relf.⁵

Waters explained that in Philadelphia, low-income minority women were enduring discriminatory treatment during various women's health-related medical visits and procedures. She and her coalition realized the need to address the disparities faced by marginalized groups of women as a result of the "Triple Jeopardy" of race, class, and gender. In light of the larger national women's health movement and its primary focus on middle and upper class women's concerns, Triple Jeopardy became both a social support and political platform for minority women in Philadelphia (C. Waters, oral history interview, September 2012).

Activists from Philadelphia's Triple Jeopardy modeled their women's health activism in a parallel fashion to many of the Black Panthers' health activism strategies. The activists not only supported women's health in the minority community, they also supported many Black Nationalist causes as well as involvement in the African liberation movements. Triple Jeopardy also worked with other groups for social change and liberation such as the Asian community's Yellow Seeds activist group in Philadelphia.

Considered an important precursor to progressive Asian American political activism in Philadelphia, Yellow Seeds was an Asian American anti-imperialist organization established in 1971 that focused on the local Chinatown as well as city, national, and world affairs. Modeled after the Black Panther Party, Yellow Seeds also published their own article, *Yellow Seeds* (1972–1977).⁶ They also involved the Puerto Rican Young Lords and their families in their outreach. Founded in 1968, The Young Lords Organization built itself upon the platform of independence for Puerto Rico as well as the improvement and empowerment of poor Puerto Ricans in the barrios of Chicago and New York City.

Walters explained that initially Triple Jeopardy was primarily concerned with guaranteeing the reproductive rights of socioeconomically disadvantaged women of color. Unlike the larger national women's reproductive rights movement that focused largely on abortion access, minority women also faced many cases of forced sterilization. Yet, in Philadelphia, the leadership of BEDC, the majority of which was men, was not supportive of the Triple Jeopardy activists' reproductive rights agenda. Philadelphia's BEDC ideologically supported national claims by the Nation of Islam and the Black Panther Party that any contraceptive use among blacks would inevitably lead to the genocide of the population.⁷ This ideological divide over birth control and reproductive rights led to the threat of a lawsuit and Triple Jeopardy's eventual split from the BEDC (C. Waters, oral history interview, September 2012).

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

As an example, Waters recounted the story of a young black woman who wanted to stop taking birth control pills and try another form of pregnancy prevention. Her provider would not listen to the young woman, each time attempting a different dose or variety of the birth control pill. Waters accompanied this young woman to her next appointment and challenged the doctor's rationale for continuing the birth control pills when the patient was experiencing numerous, consistent negative side effects. The doctor finally conceded and worked with the young woman to change the birth control plan (C. Waters, oral history interview, September 2012).

Triple Jeopardy activists also accompanied women who were in labor to their hospitals to provide support and also to ensure "... their rights were not being trampled on..." (C. Waters, oral history interview, September 2012). At the time, there were growing accounts of Philadelphia hospitals' differential treatment of minority and welfare recipients. The support that Triple Jeopardy activists lent to laboring minority women differed greatly from the growing labor support and birth movement of the 1970s. The birth movement of the 1970s was a primarily white, middle, and upper class movement, similar to the national women's health movement. Concerned with giving the laboring woman a respected and decisive voice in her labor and birth, the national birth movement fostered a new sense of empowerment with the birth process that advocates argued produced a healthier mother-baby couplet.

For most poor, minority women, however, the birth experience was often removed from their control because of their assigned status as a welfare recipient and the racialization of birth. Indeed, as Dorothy Roberts argues, white childbearing was generally thought to be a beneficial activity because it brought personal joy and allowed the nation to flourish. Black reproduction, on the contrary, was perceived many as a form of degeneracy, with black mothers seen as corrupting the reproduction process at every stage. According to these

perceptions, they damaged their babies in the womb through their bad habits during pregnancy, and then imparted a deviant lifestyle to their children through their example. These representations of black women's bodies thus warranted strict measures to control their childbearing rather than wasting resources on useless social programs.⁵

In this social environment, Triple Jeopardy activists counseled women to think carefully over any medical suggestions as to permanent sterilization procedures. In the oral history interview with Cynthia Waters, she shared that many minority women from Philadelphia found themselves convinced by medical practitioners to undergo hysterectomies during periods of the year when medical residents needed the surgical experience. Waters and the other activists in Triple Jeopardy sought to make sure their contingency of minority women were made aware of other pregnancy prevention measures in addition to the permanent sterilization measures (C. Waters, oral history interview, September 2012).

Race and health disparities

Therapeutic pain management in African Americans with sickle cell disease was another issue identified nationally in the 1970s related to race and medicine. As Keith Wailoo argues, the early 1970s witnessed a growing recognition of the pain and suffering endured by sickle cell anemia patients. As the decade progressed, however, the authenticity of pain experienced by the disease's victims fell under widespread societal scrutiny. Some viewed the pain relief sickle cell anemia victims sought as "drug-seeking" thereby casting the disease's victims as suspicious and worthy of intense scrutiny.⁸ This societal shift in recognizing pain authenticity also affected women in Philadelphia who were going through the birth and postpartum phases of motherhood.

For example, Waters shared the account of a young woman who had been treated at a local hospital for a severe Infection of the breast after delivering her infant a few days prior. The young woman was in acute pain from the infection and told the Triple Jeopardy activists that not only were the nurses withholding pain medication from her, one nurse in particular told her that because she was on public assistance, she should limit her requests for pain medication. The Triple Jeopardy activists organized a march outside of the hospital with several Black Panther Party members to protest this woman's treatment. Waters recalls how, despite being one of the most vocal organizers and protesters at the event as well as the person holding the bullhorn, she was not arrested. Instead, the Black Panther men, who were there only as a supportive presence, were taken into police headquarters and charged with civil disobedience (C. Waters, oral history interview, September 2012). Their arrest was the result of the contentious history between Philadelphia police and the Black Panther men. In the midst of these injustices, the women's health movement was bringing its agenda into urban cities and intersecting with minority-based movements.

Leading the MCC: A lawyer, a doctor, and a nun

The totality of energies emerging from the larger women's health movement supplied valuable momentum to Philadelphia's efforts to maximize women's health. Philadelphia's MCC was founded in 1980 and originated as a subcommittee of the Women's Health Concerns Committee. The South-eastern Region of the Pennsylvania Department of Health

created the Women's Health Concerns Committee in the fall of 1974. Its major emphasis rested with the concern that there should be more communication between the government of Pennsylvania and women's organizations.⁹ Local Philadelphia activists were already discussing the city's high infant mortality rates and how they envisioned meaningful change. The MCC started as a conversation between Edward Sparer, Walter Lear, and Sister Teresita Hinnegan (J. Fisher, oral history interview, July 2012). The combination of these 3 personalities and their professional backgrounds served as a powerful catalyst to the formation of the MCC.

Edward Sparer—A 1959 graduate of Brooklyn Law School, Sparer was a pioneer in the fields of poverty and health law, and he had an inspiring career as a nationally recognized teacher, scholar, and activist. He was a founder of both the first neighborhood legal services program, Mobilization for Youth Legal Services, in New York City and the first national support center for legal services work, the Columbia Center on Social Welfare Policy and Law. Sparer was “the intellectual architect of the legal strategy of the welfare rights movement.”¹⁰

Walter Lear—An activist early in his life, Lear entered medical school during a time when Jewish and black applicants were typically turned away. Lear soon found himself lobbying for racial equality in the medical profession. During the 1960s, he became inspired by the sit-ins and freedom rides as he continued to work for racial equality in the medical profession. From 1961 to 1963, he was a consultant for the National Urban League, doing research and writing that led to the publication of *Health Care and the Negro Population*.¹¹

Sister Teresita Hinnegan—Sister Teresita Hinnegan, Catholic sister, nurse midwife, with a master's degree in social work, was a University of Pennsylvania nursing instructor and health policy activist. As such, she was one of the most influential participants in this grassroots collective. Her life of social justice-related work served as a defining and vital component of her life commitment as a Catholic sister. Sister's dedication to social movement work is an example of how deep religious identities can serve as pathways to continued participation in a wide range of activist actions. In an oral history interview, Sister shared some insight into what led her into her life work of advocating for women. From 1955 to 1969, she worked as a Medical Missions sister with the poor in Bangladesh. She came back to the United States to help her sister who was then alone with 2 children. It was then that she noticed, “... how dysfunctional the system was for women with children to get the help they needed.” While helping her sister, she worked as a nurse-midwife in a Philadelphia community health center, where she witnessed the lack of health care resources for women living in poverty. These experiences influenced her decision to return to school for a Masters in Social Administration at Temple University. She stated, “I learned a lot, again, about the system and how dysfunctional it was and the change that was needed.” Sister Teresita combined her triad of professions—nursing, social work, and ministry—into a forceful tool for understanding and working for social justice (ST Hinnegan, oral history interview, November 2007).

Sister Teresita, Sparer, and Lear became the intellectual force behind the ideological and tactical beginnings of the MCC in the 1980s. The 3 activists knew their struggle to reduce

infant mortality in Philadelphia had to begin with a purposeful study of the area and the issues. Sister was given the important foundational role of organizing and conducting the study. Her detailed quantitative and qualitative analysis of Philadelphia's areas of highest infant mortality told the story of a city's failure at effectively providing care for its minority infants (personal papers of Sister Teresita Hinnegan, *Plan for the Provision of Maternity Services in Health Districts 5 and 6 [Lower North Central Philadelphia]*). It also revealed persistent accounts of institutionalized racism as minority women were reportedly turned away from area hospitals if they could not pay a cash deposit before being admitted in labor to the hospital. The activists, however, often had to use creative methods to expose acts of inequality in some of the area hospitals.

Sister Teresita and her cohort of fellow activists pretended to be low-income patients calling for obstetrical appointments. In one hospital's case, the admitting clerks asked all the activists for preadmission cash deposits of \$1000.00. Eventually, with the evidence at hand, the hospital administration conceded this was in fact happening. In many cases, they were turned away due to not having insurance. The MCC activists, under the guidance of Sparer, introduced a lawsuit in 1984 against this hospital. They later settled this lawsuit when the hospital agreed to stop this illegal action (ST Hinnegan, oral history interview, June 2009).

One of the areas of her study that moved Sister Teresita greatly was the qualitative portion of the study. Sister and a group of activists surveyed the streets of the 2 health districts by talking with the women. She said the women had stories to share with the interviewers, stories of how they were treated by hospitals and clinics and how they felt about that treatment. Many of the women shared that before the survey no one really took the time to listen to them. Sister stated that one particular woman shared that she "felt like a slab of meat" in the hospital because no one looked upon her as though she was worthy of his or her attention. In a soft voice, Sister explained during her oral history, "... because nobody cared. Nobody cared." Part of what Sister and her fellow activists did was to bring these stories of institutionalized racism to city officials. She felt strongly that an important component of MCC's activism was to help these women develop their own voices so they themselves could bring their stories forward as opposed to allowing the inequities weigh them into submission (ST Hinnegan, oral history interview, June 2009).

Plan for the provision of maternity services in Philadelphia health districts 5 and 6

In 1978, Sister Teresita initiated a selective area analysis of Lower North Central Philadelphia (Philadelphia's health districts 5 and 6) to examine factors that influenced pregnancy outcomes. The study provided a comprehensive look at the 2 health districts' transportation access, racial compositions of the neighborhoods, number of residential structures that had been vacant for a long period of time, and the Capital Program Projects for the areas. She looked at the sites for pregnancy testing and prenatal care, the hospitals use for childbirth in the identified health districts, as well as the low-birth-weight statistics and infant death statistics (personal papers of Sister Teresita Hinnegan).

Another important component of the study was a survey of the hospitals from health districts 5 and 6 women used for their obstetrical services. Sister asked local neighborhood volunteers to perform 1 part of the survey. This component looked at the hospitals in terms

of their facilities and what they offered to patients such as financial assistance, educational programs, translation services, and the amount of sibling and father involvement as well as rooming in and breast-feeding support for the women.

Sister Teresita found that women from the health districts received inadequate prenatal care and experienced a high number and rate of low birth weight babies as well as a high rate of infant mortality (see Table 2). The socioeconomic profile of the area indicated: widespread poverty, high unemployment, under employment in low-paying dead-end jobs, and low educational achievement. The housing profile indicated that people were living in environments that had been allowed to deteriorate and that attempts to rehabilitate the neighborhoods had been minimal (personal papers of Sister Teresita Hinnegan).

In her study, Sister acknowledged the influences of poverty, social deprivation, and low educational levels on the high incidence of both low-birth-weight babies and high infant mortality. Quality prenatal care programs were seen as arbiters; however, many of the low-income women were not fully accessing and/or using the prenatal services. On the contrary, the same services lacked the important outreach programs, support services, and interagency coordination that linked the pregnant woman with a continuum of care in her environment.

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

MCC, mom mobile, and maternity care advocates

The Black Panther Party's health politics "serve the people" programs played a central role in MCC's organizational activities. Attention to community service was an expression of Panther commitment to their ideologies and practice in response to their frustrations with what they deemed black cultural nationalists' preoccupation with rhetoric and the limitations of the War on Poverty programs. The Black Panthers also successfully employed outreach tactics using mobile health vans. Some of these mobile health vans were old ambulances. One of the most effective programs developed by MCC closely resembled the Black Panther's use of mobile health vans.¹²

The Mom-mobile and the Latina Mom-mobile were MCC's innovative way of reaching into the affected communities within Census Tract 152. Consisting of bright yellow vans staffed by trained community advocates, the Mom-mobile program provided pregnant women with blood pressure checks, assistance in enrolling in prenatal care, Medicaid, Food Stamps, and other relevant programs. "Maternity Care Advocates" were MCC employees who were also trusted and respected members of the affected communities. In addition to finding pregnant women who were not enrolled in prenatal care, these advocates also tried to locate and assist homeless and addicted pregnant women.⁹

These community advocates were usually older women who resided in the same low-income neighborhoods as well as minority women who had experiential knowledge of the loss of an

infant. The notion of using community members toward health promotion is a powerful idea that other groups such as the Black Panthers employed with great success. Staffed also with medical assistants, this unique outreach program brought a new kind of health promotion with services such as pregnancy testing and subsequent linkage to prenatal care for low-income women in their neighborhoods.⁹ In addition to prenatal health promotion, MCC played a crucial role in low-income women's increasing sense of empowerment through various social support programs such as classes on consumer rights in health care and how to navigate hospital system barriers.

The Philadelphia welfare rights organization

One of the MCC's most effective on the ground activities was its alliance with the Philadelphia Welfare Rights Organization, Dorothy Jordan, a former welfare recipient, became an advocate to the women in the communities MCC served. Jordan rose in the ranks of the Welfare Rights Organization initially by being asked to take over a class on welfare rights in which she was an attendee. In her words, she shared, "... my training started on the ground and never looked back" (D Jordan, oral history interview, December 2012). Eventually, Jordan became involved with the MCC as an advocate. Her role included counseling women who missed prenatal appointments; searching in the communities for women who missed prenatal appointments, recruiting pregnant women into prenatal care, and assisting these women obtain necessary social services such as food stamps, Women Infant and Children assistance, and other forms of social support. Eventually, the MCC and Philadelphia Welfare Rights parted ways as in Jordan's words, the "MCC was not into jumping on tables, shouting and demanding action for welfare mothers like some of the leadership in the Philadelphia National Welfare Rights Organization. The MCC way of doing things was to talk more and come to solutions." When asked why she stayed with the MCC, Jordan replied that she felt "they were doing things differently but effectively. There wasn't just one way to get change" (D. Jordan, oral history interview, December 2012).

Maternity care advocates such as Jordan were mature and trusted women from the affected communities who contributed greatly to MCC's vision of bringing the community into awareness of maternal-child health. These women, who knew their neighborhood well, would canvass the area for pregnant women and distribute MCC educational materials as well as encouragement to seek health services. The client advocacy project helped 131 clients between July and November 1984 and was funded the most part of the Henry Tower Wurts Memorial. They received a grant of \$2500. The money was spent for a Client Advocate/Educator, Jordan, and transportation for the advocate.¹³

Philadelphia's MCC drew its activist representation from both the professional and public realms. Professionals such as nurses, doctors, and social workers attempted to work collaboratively with each other as well as share a mutual commitment to bridging the gap between them and minority communities. A fundamental characteristic of the MCC was a commitment to democratic ideals. This ideal meant the organization was created on the basis of social arrangements that were inclusive of all people regardless of class, race, nationality, ethnicity, gender, or sexual orientation. This also meant a shared understanding that everyone, not just socially recognized experts, is capable of developing ideas.¹⁴ The MCC

operationalized the belief that people's ideas are shaped by their location in society and that those who are located in the marginal positions in society are particularly capable of thinking critically and insightfully about social problems as well as their own situations. This type of mindset allowed communities to harness their own sense of power as they assumed ownership of the issues and solutions.

The MCC survived and flourished as a result of strong community engagement and support as well as an inclusive, nonhierarchical, and collaborative style of management. Thirty-two years later, MCC has evolved from an initial staff of 3 to a staff of more than 100 and from a budget of \$116000 to a budget of 8 million. Looking back, Joanne Fisher, executive director of the MCC, reflects that birth has always attracted her interests, whether it is the birth of an infant or the birth of an organization. What continues to challenge Fisher is that she has not seen things get better in terms of the social commitments surrounding childbearing and supporting families (J. Fisher, oral history interview, July 2012).

DISCUSSION

The MCC considered the cause of high infant mortality rates in Philadelphia as arising from a combination of factors. Hospital systems failures coupled with marginalized communities' lack of education, resources, and social support were viewed as foundational to the problem. As advocates surveyed women on the streets of Philadelphia and listened to their stories, they quickly learned of the institutionalized forms of racism occurring in the city. Issues of health disparities were recognized as issues of social equity. Many low-income, marginalized women received prejudicial treatment in medical institutions that in turn prompted the activists to confront these institutions directly. At times, the negotiations became contentious. The activists employed a grass roots style of participatory democracy in which all members of society as well as the affected communities were invited to join the activism to change the landscape these women faced.

Over time, Philadelphia infant mortality rates slowly declined. For example, in 1990, health district 5 infant mortality rate was 21.2 per 1000 live births.¹⁵ Major accomplishments of the MCC were its strong advocacy and social support to communities of marginalized women. The trust the organization garnered from the affected communities fostered the women's self-empowerment process. Women felt they owned and held control over their health as opposed to it belonging to uncaring health systems. They learned to negotiate with health care systems as well as learned their rights as health care consumers. Once the momentum of education, support, and advocacy was started, the community became leaders in the process. The results were changes in both macro and micro systems surrounding the women. Ultimately, with this high touch, highly collaborative style of organizing; the women in the communities became self-empowered to seek and expect quality prenatal care.

The study of family and community health through a historical lens can provide powerful insights into present day problems that are reflected not only in health care systems but also in our nursing education programs. In terms of our health care system, history allows us to look back; consider how a community's sociopolitical context affected health and ultimately develop strategies for the present based on our lessons from the past. While we struggle

today in America to redesign our health care system, the activists, organizations, and communities described in this article successfully used grass roots, inclusive, participatory, and democratic strategies to achieve substantial changes for individuals, systems, and communities.

Armed with qualitative and quantitative data, individual stories, professional and public activism, and expert knowledge of the social, medical, and legal system, MCC activists successfully helped transform health care in Philadelphia and increase health equity for many citizens. Currently, engaging with communities is an emerging theme not only within health and social policy circles but also within nursing academic programs. For example, the University of Pennsylvania School of Nursing conducts its clinical experiences within West Philadelphia. This city neighborhood is where the students live, practice, and currently engage with their neighbors in partnerships that encourage healthier outcomes.¹⁶ Lessons from the past clearly outline the knowledge, skills, and attitudes necessary to assume successful community leadership roles. Our students need to understand that the ecology of health extends well into every system that influences the individual and family.

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Table 1

Infant and Neonatal Deaths by Location in 1980^a

Infant Mortality Rate 1980 ^b (per 1000 Live Births)				
	Census Tract 152	Philadelphia Health District 5	Philadelphia	Pennsylvania USA
Infant deaths (up to age 1)	34.7	27.3	18.1	12.5
Neonatal deaths (in first 27 yrs)	20.8	19.6	12.5	8.4

^a Reprinted from the personal papers of Sister Teresita Hinnegan (*Plan for the Provision of Maternity Services in Health Districts 5 and 6 [Lower North Central Philadelphia]*), and based on data from reference 1.

^b Data sources: Philadelphia Department of Public Health, Pennsylvania; Division of Health Statistics; National Center for Health Statistics.

Table 2

Infant Deaths by Location in 1978, 1979, and 1980^a

	1978 ^b		1979		1980		3-yr Totals	
	n	%	n	%	n	%	n	%
Health district 5	36	72.0	28	68.3	41	72.0	105	70.3
Health district 6	23	63.9	29	66.0	20	52.6	72	59.3
Philadelphia	320	74.9	310	69.3	311	69.1	941	71.0
Pennsylvania ^c	1540	75.8	1548	73.0	1530	72.9	4618	73.9

^a Reprinted from the personal papers of Sister Teresita Hinnegan (*Plan for the Provision of Maternity Services in Health Districts 5 and 6 [Lower North Central Philadelphia]*).

^b Data source: Philadelphia Department of Health. Selected resident birth and death data by the Health district, by Census Tract 1978, p1; 1979, p1; and 1980, p1.

^c Data source: Pennsylvania Vital Statistics Reports, 1978.