

Birth Behind the Veil: African American Midwives and Mothers in the Rural South,

1921-1962

by

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ABSTRACT OF THE DISSERTATION

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By the early twentieth century, the majority of white women living in the United States were giving birth in hospitals under the care of a physician. In 1921, the majority of women who gave birth under conditions that were indigenous, eclectic, spirit based, and not according to the standards of modern medicine, were the rural black women of the South. African American midwives and women of the South maintained the core qualities of the home birthing traditions, handed down through a matrilineal system of recruitment and training from the period of enslavement throughout the twentieth century. This occurred amidst a major program of midwife training and regulation. Public Health officials of the early twentieth century urged midwife regulation as a temporary measure. Medical professionals considered the lay midwives of the south a necessary evil. They were necessary because the population they served was left out of a medical system that operated according to the practices and laws of racial segregation. They were evil, however, because they were believed to carry disease, to be incapable and inherently responsible for elevated levels of infant and maternal mortality in the

South. Yet health authorities could think of no better solution than to train and regulate the best of the practicing lay midwives and eliminate those whom they considered unwilling to follow safe practices.

Despite the beliefs of the medical community, African American childbearing women of the South relied upon the services of lay midwives. The transition from home to hospital birth was not a smooth transition for rural southern women. There were socio-economic barriers to a hospital birth for many. However, there were also cultural and spiritual reasons for their preferences. They did not appear to associate midwives with unsafe conditions. In fact, the reverse was the case. This study examines the movement from the lay assisted births of the early twentieth century through the medicalized events of the later decades. African American women of the South approached modern medicine in various ways, yet always through the multiple lenses of racial segregation, deep spiritual beliefs surrounding childbirth, and the viewpoints of their ancestors. These factors were more prominent in impacting the birth experience than the views, perceptions, and regulations of the health care professionals who were officially responsible for the birth event.

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Introduction

There are many untold stories of the black South during racial segregation. Countless moments remain hidden from the analyses of historians and scholars of every field. However, some of the most sacred and protected events of human life are those that can reveal the most about the experiences of African Americans. Childbirth is one of these events. The following chapters are an attempt to unfold the events of the experience of birth among the childbearing women of the black south during the height of racial segregation. My objective is to analyze the complex interaction of race, class, religion, and health. In doing so I hope to demonstrate that even the most personal and passionate aspects of the lives of African American women during the twentieth century were subjected to medical and moral scrutiny. Their reactions to this scrutiny were equally passionate and complex. They reveal something of the inner lives of black women during a time and place when their bodies and souls were being dehumanized by the outside world.

The first chapter provides an explanation of my use of the term, “the veil,” as well as a historical overview of the time period covered, a discussion of sources and an acknowledgment of previous publications.

The second chapter is an analysis of the traditional practices and rituals of childbirth. It shows how the techniques of childbirth are a union of folk traditions, Christian beliefs, and medical procedures. This chapter demonstrates that spiritual beliefs are at the foundation of the work of midwives.

Chapter three discusses the surveillance of birth among African Americans in the South. This chapter includes a discussion of the social and racial anxieties generated by public health officials in the South, and the midwife regulation programs that were influential in transforming the experience of childbirth.

The fourth chapter deals with Tuskegee University programs of the 1930's and 1940's. Medical officials of Tuskegee were preoccupied with the practices of Alabama's traditional rural midwives. They focused on gathering information from area midwives, training, and improving the health conditions of the surrounding community. This chapter also includes a series of profiles of lay midwives who were active in Talladega County, Alabama from the 1930's through the 1950's. The focus is on the transitional figures of the time period. For the first time there were midwives who were active in the South who had gained the majority of their training from their local health department, instead of from elder midwives.

The final chapter of the dissertation is an analysis of the visual and discursive portrayals of midwives commonly found in medical journals in the 1940's. It discusses the three most common methods of portraying the traditional midwife: derogatory language, photography, and use of dialect. Untrained midwives were often described as ignorant, and dirty. Medical journals of the time period often juxtaposed these images with ones of trained midwives who were often described as neat, orderly, and bearing the physical markers of a medical professional. They were making the point that state regulation had transformed the midwife. Indeed it had. But in ways that were not always publicized in these journals. African American midwives of the South began to take a more active role in spreading health care information throughout the South. They encouraged the women under their care to be seen by a physician at least once during their pregnancies and helped increase attendance at prenatal and maternal

clinics in their communities. There had been many changes along the way from 1921, and yet the spirit of the black midwife remained with childbearing women of the black south through the final transition to the hospital room.

Chapter One: The Veil

I was plowing in the field, plowing cotton, when a voice within told me he wanted me to be a midwife, to take care of mothers and babies. The Lord showed me just how it was to be done.

Testimony of lay midwife – Northern Florida¹

The Negro is a sort of seventh son, born with a veil, and gifted with second sight in this American World.

W.E.B. DuBois²,

Some superstitions which came up provoked argument among the midwives. Somebody said a baby born with a veil could foresee the future and see spirits. She said when little children stop, shiver, and “scrunch up” they are seeing spirits.

Marie Campbell³

The craft of midwifery has a long tradition of being associated with the divine. Oral testimonies of female African-American midwives are rich with descriptions of visions and direct communication with God. Testimonies, such as the one noted above, is indicative of the relationship African American lay midwives felt with a divine being. They believed they were called by God to be midwives, and that The Lord guided their work. The notion of “the veil,” which was put forth by W.E.B. DuBois in the early twentieth century is helpful in understanding the role that midwives played in the communities they served. There are multiple meanings of the “veil,” in this study. Midwives commented on the physical veil, or caul, that some infants were born with. This was a newborn who was born with part of the amniotic sac covering its face. This could be a dangerous condition for an infant. It was also a sign, among traditional

¹ Molly Dougherty, “Southern Lay Midwives as Ritual Specialists,” in *Women in Ritual and Symbolic Roles*, ed. Judich Hoch-Smith and Anita Spring (New York: Plenum Press, 1978), 153. The passage is from an oral interview conducted by the author with a lay midwife in northern Florida.

² W.E.B. DuBois, *The Souls of Black Folk* (New York: Bantam Books) 1989. Original edition published in 1903.

³ Maria Campbell, *Folks Do Get Born* (New York: Garland Publishing) 1946. P. 36.

birth attendants of the South, that the child would have an especially close relationship with the spirit world. The following is an account from a Virginia midwife:

I had to get to work right away, because the baby was born with a veil over it's face. At the time, I was trying to get the veil off, I didn't know if the baby was dead or alive. I ran my fingers a the neck part and pulled it up over the head, but the baby had already suffocated. The lady there with the mother said she had tried to get it off, but she didn't succeed. That one was the only one I have seen or delivered, being born with a veil over it's face. But you know what they used to say, that a baby born with a veil over its face could see things that a normal person didn't see.⁴

Some midwives were themselves born with a veil. It is also meant to explain the multiple positions and viewpoints they held in their world.

Religion, spirituality, and folk traditions played a central role in the experience of birth among African-American women of the South. As discussed here, the role of religion in the childbirth experience was both deeper and more complex than presented in ethnographic and social scientific studies of African-American midwives.⁵ In fact, during the height of the Jim Crow era in the South, the spiritual beliefs of midwives and mothers comprised the central axis around which the story of childbirth rotated. The story of childbirth among black southern

⁴ Claudine Curry and Mildred H.B. Roberson, *My Bag Was Always Packed: The Life and Times of a Virginia Midwife* (Bloomington: 1st Books, 2003), 35.

⁵ For studies that have detailed descriptions of the spiritual practices of African-American lay midwives, see Marie Campbell, *Folks Do Get Born* (New York: Garland Publishing, 1984); Dougherty, "Southern Lay Midwives as Ritual Specialists"; Linda J. Holmes, "African American Midwives of the South," in *The American Way of Birth*, ed. Pamela Sue Eakins (Philadelphia: Temple University Press, 1986); Margaret Charles Smith and Linda J. Holmes, *Listen to Me Good: The Life Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996); Onnie Lee Logan, *Motherwit: An Alabama Midwife's Story* (New York: E.P. Dutton, 1989); Holly Mathews, "Killing the Medical Self-Help Tradition among African Americans: The Case of Lay Midwifery in North Carolina, 1912–1983," in *African Americans in the South: Issues of Race, Class, and Gender*, ed. Hans Baer and Yvonne Jones (Athens: University of Georgia Press, 1992); Debra Ann Susie, *In the Way of Our Grandmothers: A Cultural View of Twentieth-Century Midwifery in Florida* (Athens: University of Georgia Press, 1988); Mary P. Mathis, "Lay Midwifery in the Twentieth-Century American South: Public Health Policy and Practice" (PhD diss., Florida State University, 1990); and Beatrice Bell Mongeau, "The 'Granny' Midwives: A Study of a Folk Institution in the Process of Social Disintegration" (PhD diss., University of North Carolina, 1973).

women is related to W.E.B. Dubois's early twentieth century explanation of "the veil." DuBois believed that African Americans had a unique perspective on American society, as they were able to see it from behind the veil of race. They understood white American society well. They had to in order to survive. They also knew that a part of their experience was unknown to the white world. In a sense, the white world would not and did not see their "soul." This was partly for the sake of self-preservation, and partly because the wider community at this time in history would not have believed a deeper, more complex world existed among black Americans. The stories of childbirth are similarly complex, hidden, and soulful. African American mothers and midwives knew this world very well. Fragments were visible to white Americans and to southern physicians in particular. Midwives had a unique perspective throughout the twentieth century on childbirth, black systems of health care and modern medicine. They operated within all of these spheres, and seamlessly applied both traditional and modern health care to women, children, and families in their communities. This perspective is what gave them the "second sight," as DuBois characterized it, into a uniquely divided health care system.

In 1938, a midwife by the name of Lula Russeau admitted that she could "foretell the future and see spirits."⁶ Lula Russeau was born with a "caul," or veil over her face. This meant that she was born with a piece of the amniotic sac covering her face. According to Russeau this was a sign that she was going to have the gift of second sight, and have the ability to heal people. Midwives considered it their special responsibility to handle a baby born with a veil. They believed that it required a particular set of rituals otherwise the child would suffer. Black midwife, Ella Wilson, from Arkansas, believed the caul required "special handling," and that it should be saved until it disintegrated. Another woman, Maum Hagar, of South Carolina, made a

⁶ Fett, 53.

special tea from the caul, which was, she believed, prevented the child from seeing “frightening supernatural forces.”⁷ Others stated that if the veil was taken off backwards, the child would not be troubled by spirits.⁸ For Lula Russeau, it was a special sign that marked her as a person who would be a gifted healer to her community. It was a sacred sign.

“I was born one [a midwife],” she stated; “God made me dat way.”⁹ She was also born into a maternal lineage of healers. She had learned about traditional healing methods, including the use of herbs and charms, from her mother. Sharla Fett states that, “the matrilineal lineage of healing abilities merged with special birth signs and the sense of divine calling to form the foundations of her legitimacy as a healer.”¹⁰

The women discussed in the following chapters, like Russeau, have a special relationship to the history of medicine in this country. They had a second sight into the world of race and medicine in the twentieth century. Some were gifted healers. Others were deeply imperfect and at times a risk to the women under their care. In order to understand the lives of African American women of the rural South during the twentieth century we must fully account for the contradictory and complex nature of the experience of childbirth.

The first several decades of the twentieth century is the period of rapid decline for lay midwifery nationwide. In 1921, a major phase of midwife education programs began in most Southern states. The 1930’s and 1940’s are also critical decades and periods of transition for African American childbearing women. While some critical information preceding and following these decades is included, the focus of the present study is on the 1920’s through the

⁷ Marie Jenkins Schwartz, *Birthing a Slave: Motherhood and Medicine in the Antebellum South* (Cambridge: Harvard University Press, 2006), 150-1.

⁸ Campbell, 36.

⁹ Fett, 53.

¹⁰ *Ibid.*

late 1940's. African-American midwives were very active during this time, and were central to the experience of childbirth in the South. This was a time when dramatic demographic shifts were taking place in the rural south. Between 1910 and 1930, more than 1.5 million African Americans migrated out of the rural south. The people who left were primarily agricultural workers who were fleeing the devastating effects of the boll weevil, extensive poverty, and racial exclusion.¹¹ "Between 1910 and 1920, 10.4 percent or 200,400 African Americans left Alabama and Mississippi alone for the promise of a better life beyond the South; and an additional 2 million departed from the region between 1930 and 1950."¹² The social impacts of World Wars I and II were central to the migrations of African Americans out of the South. "Pushed by wretched agricultural conditions and pulled by war industries that offered jobs with high and regularly paid wages, more African Americans fled the land."¹³ This study begins immediately following the first wave of the Great Migration and proceeds through the second. However, in many ways it is a story of the people who stayed behind. The women included in this study were rural agricultural workers of the Deep South. They were part of the diminishing population of black farmers. By 1950, 25 percent of southern farmers were black. In this decade almost 2.5 million more African American farmers left the South. By 1960, African American farm workers were "nearly irrelevant."¹⁴

The black farmers who remained in the South during these years lived under very harsh circumstances. In 1918, William Edwards, an African American educator who worked in Alabama spoke about the conditions of black people in the South: "These people are hungry,

¹¹ R. Douglas Hurt ed., *African American Life in the Rural South, 1900-1950* (Columbia: University of Missouri Press, 2003), 2. See also, Stewart E. Tolnay, *The Bottom Rung: African American Life on Southern Farms* (Urbana: University of Illinois Press, 1999), 14.

¹² Hurt, *African American Life in the Rural South, 1900-1950*, 2.

¹³ *Ibid*, 3.

¹⁴ *Ibid*, 4.

they are naked, they have no corn and had no cotton; so they are without food and clothes.”¹⁵

Most African American farm families who lived in the South in the first decades of the twentieth century lived in dilapidated houses and without indoor plumbing, window screens, or electricity. In 1934, one in three houses of black farmers in the Eastern cotton states had no sanitary facilities. In his survey of 916 rural families living in eight counties of the rural South, sociologist Charles Johnson noted that, “the majority of houses were more than twenty-five years old and had major physical defects, including leaking roofs, broken porches, and defective floors.”¹⁶ Families were crowded in these two or three room structures. Their diets were also lacking in nutritional value. One observer noted that, “food is scant in quantity and poor in quality, and a diet too largely composed of meal, salt pork, molasses results in high sickness and death rates.”¹⁷ Economic hardships and the difficulties of farming were some of the factors that contributed to the steady movements of African Americans in this period.

Movement is a prominent theme of accounts of black southern life during the first half of the twentieth century. Many men and women fled rural areas for the urban centers of the South and North. However, some studies indicate that the scope of much of the movement was limited. A 1926 study of Southampton County, Virginia, found that while almost all tenant farmers moved at some point during their lives, the majority of them stayed within the same county. They moved from farm to farm, but the majority (81 percent) maintained the same church, school and store as before their move.¹⁸ “Another 1924 study of tenant farmers across ninety-three southern plantation counties found similar levels of farm-to-farm mobility among both blacks and

¹⁵ Louis M. Kyriakoudes, “‘Lookin’ for Better All the Time:’ Rural Migration and Urbanization in the South, 1900-1950.” In R. Douglas Hurt ed, *African American Life in the Rural South*, 12.

¹⁶ Tolnay, 31.

¹⁷ Tolnay, 130. Hurt, 4.

¹⁸ Kyriakoudes, 15.

whites.”¹⁹ The same pattern continued throughout the Depression era years. Additionally, the “typical move” of southern farm couples in the 1940’s did not cross county lines, and “those that did covered a distance of only thirty to forty miles.”²⁰

The African American population that is the focus of this study constituted the group that remained in the South, while perhaps moving from farm to farm. What is also critical for our understanding of the experience of birth is that those who remained, maintained relatively high levels of fertility during the period covered. The fertility rates among African American southern women declined between 1900 and 1940 yet remained high, relative to other populations. The ratio of children younger than five per one thousand women ages fifteen to forty-nine was higher among southerners, than that of the national average during the first half of the twentieth century. In addition, the rural population of the South grew during these years despite the heavy out migration. It rose from 17.8 to 22.7 million from 1900 to 1940.²¹ At the turn of the century, the average black woman of the rural south was likely to give birth to about seven children. In 1940, the average number was five.²² Large families were a social and economic necessity of southern farm families, who expected their young children to contribute to the household economy. In addition, black farm families lived in isolation of the fertility trends of women in other areas. They were not impacted by the fertility trends of women in urban areas of the North and South.²³ The African American midwives and mothers, who are at the center of this study, were concerned with caring for the large numbers of births that remained typical among families of the rural south. While they did not face social dislocation from a move to an

¹⁹ Ibid.

²⁰ Tolnay, 141.

²¹ Kyriakoudes, 19

²² Tolnay, 17.

²³ Ibid, 17-18.

urban area, they did confront issues of modernity and negotiated the shifting landscapes of childbirth regulation.

The traditional African-American midwife, or the “granny” midwife, was considered a danger to women and babies by medical professionals in the early twentieth century. White doctors who sought entry into the growing field of obstetrics launched a campaign against midwives in the first decade of the twentieth century. Photographs of elderly midwives were published to promote the idea that these women were diseased, ignorant, and superstitious, and thus a danger to childbearing women. A frequently used set of images shows a “granny” midwife next to a photograph of a “typical Italian midwife” and an Irish-American midwife. The Irish woman is quoted as saying, “I am too old to clean, too weak to wash, too blind to sew, but thank God, I can still put my neighbors to bed.”²⁴ The caption goes on to compare the immigrant women to the “granny of the far South.” The African-American midwife is described as “ignorant and superstitious, a survival of the ‘magic doctors’ of the West Coast of Africa.”²⁵ The medical professionals who distributed this material intended to scare women of the urban Northern United States away from the traditional childbirth attendant and toward the services of physicians. The midwives, who represented folk methods of healing that were considered dangerous and backward by medical professionals, were targeted as the cause of high infant and maternal death rates.

In the case of the African-American midwife of the South, physicians were unsure of what their position should be. They believed that the traditional midwife was a menace, but were unwilling to take on the large population of childbearing women of the South. Segregation laws,

²⁴ Richard Wertz and Dorothy Wertz, *Lying-In: A History of Childbirth in America* (New Haven, CT: Yale University Press, 1989), 216.

²⁵ Wertz and Wertz, *Lying-In: A History of Childbirth in America*, 216.

racial stereotypes, and the economic devastation of the cotton economy made it unlikely that rural black women would be attended by white physicians. Instead of using these photographs to convince black women to seek a physician, they were used to illustrate the difference between a midwife who was supervised and trained by the local health department and one who was of the “Olde Type.” A midwife who was unsupervised and practicing according to traditional beliefs was assumed to be life-threatening to the mother and baby.

Public outreach and changes in medical education carried out by medical professionals throughout the century were reactions to laypeople’s concerns about high mortality rates of infants and mothers in the early part of the century. According to J.H. Mason Knox, head of the Maryland Department of Health’s Bureau of Child Hygiene, these changes were due to the “interest and vision of lay groups of interested, socially minded men and women, who became aroused by the suffering and loss incident to the excessive mortality among mothers and infants and took practical steps to improve conditions.”²⁶ Knox told his audience in 1934 that the medical profession as a whole was not sympathetic to the plight of mothers and babies, but was reacting to public opinion. He stated that “city boards of health generally followed the paths opened by the volunteer organizations and later depended upon lay support for help in the enactment of milk ordinances and of other measures which have furthered child hygiene.”²⁷ Once the causes of infant deaths were identified, interested laypeople and those in the public health field set out to rectify them. In the early twentieth century, diarrhea and respiratory diseases were major causes of infant mortality in the first year of life. At this time, contaminated

²⁶ J.H. Mason Knox, Jr., “Reduction of Maternal and Infant Mortality in Rural Areas,” 70.

²⁷ *Ibid.*, 70.

water supplies were identified as a major public health issue contributing to high rates of infant mortality.²⁸

In 1921, Congress approved the Sheppard Towner Act, which provided the funding for local and state health departments in the South to develop programs for dealing with the midwife “problem.” The national Children’s Bureau conducted a series of studies in the first decade of the twentieth century that were intended to determine the causes of infant mortality. In these studies, low family income was the most common denominator in infant deaths; specifically, the father’s income was directly related to infant mortality.²⁹

Other studies concluded that low income was not a determining factor; rather, the mother’s inability to breast-feed her newborn was the primary factor contributing to infant death. For instance, in a paper read to the National Conference of Social Work in 1919, Julius Levy, M.D., director of the Division of Child Hygiene in the New Jersey Department of Health, stated that, “among the social and economic conditions affecting infant mortality I would not give a very important place to poverty.”³⁰ Levy found that certain social groups who were very poor had a lower infant mortality rate than other groups with a higher family income. He found that it was the mother’s ability and willingness to nurse that had the highest impact on infant mortality in the first months of life. He concluded that “maternal nursing and ‘mothering’” were the most critical factors contributing to infant health.

The infant mortality rate among African-Americans at the time of Levy’s study was two to three times higher than that of the white population. He found that higher infant mortality was

²⁸ Julius Levy, “Maternal and Infant Mortality,” *American Journal of Public Health* 19, no. 2 (February 1929): 227.

²⁹ Richard Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850--1929* (Baltimore: Johns Hopkins University Press, 1990), 182.

³⁰ Julius Levy, “Reduction of Infant Mortality by Economic Adjustment and by Health Education,” *American Journal of Public Health* 9, no. 9 (September 1919): 676.

primarily due to the occupations of African-American women and greater likelihood of work outside the home (“the percentage of colored women in employment is practically very little affected by age or marital condition”).³¹

As suggested here, there was no consensus regarding the exact causes of infant and maternal mortality. Some studies focused on socioeconomic factors and others on medical practices or the lack thereof. Obstetrical practices were a factor for many who studied the problem. Julius Levy argued that “no method of distributing modified milk, establishing mothers’ classes, and visiting new-born babies can have a very marked effect upon this mortality, as it is obviously bound up with the obstetrical problem.”³² He found that a significant number of infant deaths occurred in the first three hours of life, and that mortality in the first day for babies delivered in hospitals was three times as great as for those delivered at home. He further found that mortality for those delivered by physicians was almost twice as high as for those delivered by midwives. In the sample he studied, the mortality rate of babies delivered in hospitals was nearly four times as high as that of babies delivered at home.³³

According to a study conducted in 1927 cited by Levy, the U.S. maternal mortality rate due to puerperal sepsis (i.e., genital tract sepsis occurring during childbirth or miscarriage) or “puerperal conditions” was high when ranked alongside a number of Western European and Scandinavian countries. For instance, the U.S. rate was 6.7 per 1,000 births, compared to around three in the Netherlands, Norway, Sweden, and Italy.³⁴ A high maternal death rate due to puerperal sepsis was not always linked to race/ethnicity at the time of Levy’s study. He found

³¹ Ibid., 678.

³² Levy, “Maternal and Infant Mortality,” 226.

³³ Ibid.

³⁴ Ibid., 227.

that maternal deaths among African-American women in Virginia, Maryland, North Carolina, and Kentucky had declined from 1917 to 1921.³⁵

There were other causes of elevated maternal mortality rates as well. Levy believed that attention needed to be focused on the increasing use of forceps and general anesthesia, and the interference of the process of labor that occurred in the hospital setting when determining the causes of infant mortality.³⁶ He questioned whether it was the “greater patience exercised by the midwife” that contributed to lower maternal death rates, or whether it was that midwives were less likely to assist women who had complications.³⁷ There was no indication at this time that maternal mortality rates were directly linked to race/ethnicity or to midwife-attended births. Mason Knox also found that maternal deaths due to sepsis and toxemia were higher among physician-assisted births than by midwife. He concluded that adequate prenatal, natal, and postnatal care of the mother would drastically reduce the number of deaths.³⁸

Despite Levy’s study results, the Children’s Bureau concluded that the lack of “skilled care” during labor and birth was the primary factor to be addressed in response to high infant and maternal mortality rates. Julia Lathrop, head of the bureau, proposed that the federal government begin to take responsibility for the lack of appropriate prenatal care among rural and low-income families in the United States.³⁹ The Sheppard Towner Act of 1921 made available funds that were to be used for education and training in each state requesting them. The money was channeled through the Children’s Bureau. A program for midwife registration and education was one of the most prominent efforts funded by the Sheppard Towner Act. Since African-

³⁵ Ibid.

³⁶ Ibid.

³⁷ Ibid., 226.

³⁸ Knox, “Reduction of Maternal and Infant Mortality in Rural Areas,” 69.

³⁹ Wertz and Wertz, *Lying-In: A History of Childbirth in America*, 206.

American midwives of the South were the largest group of unregulated childbirth attendants in the United States, the programs focused on the “granny” midwife.

The Children’s Bureau made it clear that their focus was on infant mortality among certain ethnic groups.

Our complex population is a factor that has influenced infant and maternal mortality rates in the United States. Practically every State has initiated work directed towards the problems of a specific foreign-born people or racial group that has composed part of its population.⁴⁰

Midwife regulation work was organized around the belief that the methods used by traditional birth attendants in black and immigrant communities were causing deaths and complications, despite evidence that infant mortality rates among births attended by midwives in the urban North were lower than among those attended by physicians. Typically, midwives had an apprentice-type of relationship with local physicians; during this phase of regulation, state health departments took over midwife training, education, and supervision.

Public health nurses focused on preventing midwives who were considered unfit from practicing, and on training those who remained according to health department standards. A public health nurse in charge of midwife regulation in South Carolina described the midwife problem in her state as a “most difficult and gigantic one.” In 1920, she said, “Twenty per cent of white mothers, and eighty per cent of colored, depend upon dirty, ignorant negro women for care at a time when they should have the most skilled attention. The midwife can not be eliminated. She must be made the best of as a bad bargain.”⁴¹ Other public health nurses referred to the “granny” as a “necessary evil.” In Mississippi, Alabama, South Carolina, and other Southern states, public health nurses and doctors used funds provided by the Children’s

⁴⁰ Ibid.

⁴¹ Ruth Dodd, “Midwife Supervision in South Carolina,” *Public Health Nurse* 12, no. 10 (October 1920), 863.

Bureau to transform the practices of African-American midwives. The resulting interaction among African-American midwives, childbearing women of the South, and Southern medical professionals who were influenced by Northern medical institutions constitutes a principal focal point of this study.

The objective of the Children's Bureau and the state boards of health were to transform, through education and regulation, the practice of midwifery in the South. Bureau officials claimed that a "better type of negro midwife" was being developed, and that the "old, unfit, the diseased, ignorant, superstitious, and dirty midwives are being eliminated."⁴² Midwives were trained in cleanliness techniques, how to prepare a room for delivery, the stages of labor, and when to call a doctor. They did not receive any medical training or information that would help them to alleviate the physical pain of a woman in labor, or to deal with common complications such as hemorrhage or stalled labor.

The appearance and hygiene of the midwife changed more than her access to modern medical techniques or her ability to alleviate the suffering of a woman in labor. In Mississippi, the head of the state board of health claimed to have solved the problem in his state when he could assert that the gatherings of midwives had changed from "a dirty, disorderly group, talking and paying little attention, to a group dressed in clean white uniforms and caps all eager to learn."⁴³ Across the South, nurses conducted demonstrations and training sessions. Nurses and public health officials stressed the importance of cleanliness.

Beside a kitchen table borrowed for the occasion stood the nurse with the demonstration materials. In front of her were arranged the twelve "mammies," each resplendent in garb of

⁴² U.S. Department of Labor, *The Promotion of the Welfare and Hygiene of Maternity and Infancy Act*, Children's Bureau Publication 186 (Washington, DC, June 30, 1927), 20.

⁴³ Felix Underwood, "Twenty-five Years in Maternal and Child Health," *American Journal of Public Health* 38, no. 11 (November 1948).

snowy cap and gown, and each bearing proudly a little black bag to be presented to the nurse for inspection. The opening of these bags revealed an interior perfect in detail of equipment.⁴⁴

This description of a midwife training session illustrates a common dichotomy found in medical publications in the 1920s. The use of the term “mammies” associates the women with domestic work and subservience. The caption uses the “mammy” stereotype to conjure an image of a loving but ignorant caregiver. The image of the “mammy” and the “granny” share characteristics of the period’s racial stereotypes. When referred to in this way, the midwife is disassociated from anything medical. The little black bag, however, refers to a black leather doctor’s bag. These bags were distributed to midwives of the South and were meant to replace the cloth sack that held a midwife’s supplies for a birth. The midwife was only allowed very specific items for the bag and these were to be kept clean and orderly. The midwife bags were inspected regularly by public health nurses. This depiction combines imagery of the ignorant “granny” stereotype with that of modern medicine through reference to the black doctor’s bag. A clean and orderly bag was considered a victory for the health department, as some midwives were known to resent and resist bag inspections. Many midwives continued to carry illegal materials to a birth if they were requested by the mother.

The discourse generated by the Children’s Bureau and other health organizations intersected, on an aesthetic level, with the ideology of racial uplift as espoused by members of the black middle class. Kevin Gaines, in his study of the ideology of the black middle class in the twentieth century, describes the complexity of the ideology of uplift. He writes that uplift “represented the struggle for a positive black identity in a deeply racist society, turning the

⁴⁴ Ruth Dodd, “An Open Air Class,” *The Public Health Nurse* 13, no. 5 (May 1921), 289.

pejorative designation of race into a source of dignity and self affirmation through an ideology of class differentiation, self-help, and interdependence.”⁴⁵ The midwife of the “new type”—as represented in photographs—looked, dressed, and carried herself like a medically trained professional. Midwife education programs were represented as not simply training women in medical techniques, but as elevating their class identities. In one sense the interactions among African-American nurses, “granny” midwives, and pregnant women in the South were focused on providing health-care information and improving the maternal and infant mortality rate in the rural South. However, there were more complicated issues of class and race that were simultaneously being played out. The aspects of traditional health work that were most distasteful to health professionals were associated with rural Southern folk culture. They highlighted the cultural gap between childbearing women who were agricultural workers and sharecroppers, and the middle class nurses and health officials who were attempting to control and alter the birth experience through the regulation of midwives.

Historian Darlene Clark Hine has documented the struggles of African-American women to gain recognition in the field of nursing. The process of professionalization within nursing tended to harden the class-based divisions within the group.⁴⁶ African-American nurses had to “fight for every bit of recognition and fair treatment they received. Throughout the period from 1900 through 1950, professionalization for them was synonymous with struggle.”⁴⁷ It is within the context of this fight for recognition that black women nurses were involved in training midwives and educating mothers.

⁴⁵ Kevin K. Gaines, *Uplifting the Race: Black Leadership, Politics, and Culture in the Twentieth Century* (Chapel Hill: University of North Carolina Press, 1996), 3.

⁴⁶ Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890–1950* (Bloomington: Indiana University Press, 1989), xx.

⁴⁷ *Ibid.*, xxi.

In order to maintain their licenses to practice, African-American midwives had to submit themselves to inspection on various levels. Aspects of their lives and their work, which were previously hidden from the gaze of white medical officials, were routinely examined. Public health nurses throughout the South conducted random inspections of the homes of midwives under their supervision. During these home inspections, midwives presented their midwife bags and equipment for scrutiny as well. The midwife bag was a primary focus for most health department officials. The bag symbolized the autonomy of the midwife and her desire to maintain traditional practices while simultaneously embracing modern ones. Midwives were known to carry forbidden articles in these bags, such as herbal remedies, to the births they attended. The home inspection was an extension of the bag inspection. The homes of midwives were to be kept clean and orderly. Cleanliness of person, home, and equipment came to symbolize the work of the midwife and the childbirth experience she would preside over. Midwives learned aseptic techniques that were to be applied to her work as a birth attendant as well as her person and her home. These techniques served medical purposes. However, there was a larger political meaning behind the attention to cleanliness. The ideologies of uplift and the politics of aseptic techniques were absorbed, resisted, and transformed by midwives and mothers. The focus on cleanliness has implications for the larger social meaning of childbirth. It was not her cleanliness techniques or her ability to follow the guidelines of the health department that made particular midwives appealing to the childbearing women of the South. The younger generation of midwives, those who underwent training only by the health department, were the least popular among childbearing women. They were not skilled in the traditional healing methods that were important to childbearing African-American women. Women were comforted by the traditional practices and wary of modern medicine. African-American midwives

continued to use the traditional methods of healing because they brought comfort to the women they attended, and because they represented the spiritual aspects of their practice.

Certain aspects of the birth experience were visible to the medical community and others remained concealed. The birth room was an aspect of the childbirth experience that remained “behind the veil.” In his chapter, “We Are Not What We Seem,” Robin D.G. Kelly writes, “We must strip away the various masks African Americans wear in their daily struggles to negotiate relationships or contest power in public spaces, and search for ways to gain entry into the private world hidden beyond the public gaze.”⁴⁸ This study attempts to gain entry into the public and private realms of childbirth, in order to reveal the hidden agendas that black women held in regard to how they would give birth. These agendas were hidden from a world that characterized them as diseased, promiscuous, and ignorant. As Allan Brandt argues in his social history of venereal disease in the United States, medicine “is not just affected by social, economic, and political variables—it is embedded in them.”⁴⁹ When this theoretical approach is applied to the history of childbirth and Jim Crow, it reveals the complicated relationships among race, gender, and medicine.

Discussion of Sources

I obtained useful information from a wide range of primary sources, including the records of the Mississippi State Department of Health. Documents from this collection show how the image of the midwife changed over time and provide materials to describe the relationship between the midwife and the State Board of Health. I will closely analyze the Board’s *Manual for Midwives*--produced from 1928 through 1975--which was intended to be the handbook for

⁴⁸ Robin D.G. Kelly, “‘We Are Not What We Seem’: The Politics and Pleasures of Community,” *Race Rebels: Culture, Politics, and the Black Working Class* (New York: Free Press, 1994), 36.

⁴⁹ Allan Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880* (New York: Oxford University Press, 1985).

midwives throughout the state. Mississippi midwives revered the manual, and it was considered an important part of their self-education. Each volume is rich with visual imagery that will be analyzed in order to enhance understanding of the time period represented in each. The manuals contain photographs of midwives, midwife meetings, and Board-authorized midwife equipment, as well as songs and prayers used during midwife meetings. The text of the manual provides a detailed description of the techniques considered appropriate by the health department. The manuals constitute a rich source of material on midwife education from the 1920s onward.

To supplement the material found in the *Manual for Midwives*, I draw on annual reports of the Mississippi State Board of Health, as well as reports from the county Boards of Health. Particularly useful for this study were reports in the series titled, “The Relation of the Midwife to the State Board of Health.” These documents from the early 1940s describe the structure of midwife supervision in the state, as well as the activities and accomplishments of individual midwives.

Activity reports for various county-level midwife clubs describe the format and content of regular monthly meetings. Often written by the “leader” or “secretary” of the club, who was a midwife, the reports provide information on the types of songs, prayers, and demonstrations that were commonly a part of midwife club meetings of the 1930s and 1940s. They are also used to illustrate the image that midwives wanted to present to the State Board of Health, which regulated their work.

In addition to the series of reports and surveys generated by the Mississippi State Board of Health, I will analyze similar reports generated by the Alabama State Board of Health. The collection from Alabama includes reports from county health programs in the 1930s and 1940s. These reports include discussion of midwife regulation and education activities in various

counties and statistics on licensed midwives in each county and deliveries they attended. The Alabama collection includes reports from Macon County, and supplements reports from nurses at Tuskegee Movable School (located in Macon County) during the 1930s. The Tuskegee Movable School nurses recount interactions with midwives in the areas they visited, and the type of education and information they provided regarding prenatal care and childbirth practices.

A particularly useful source found in the Alabama archives is a series of midwife record cards from Talladega County. This county's Board of Health maintained a file for each of forty registered lay midwives in the area, which included personal information for each midwife. Nurses in charge of midwife supervision regularly recorded their interactions with the midwives. The notations include regular home inspections, physical examinations, and midwife club visits, as well as infractions and tensions between the nurses and midwives in the county. The series also includes information regarding investigations into infant deaths at childbirth. Similar "midwife record cards" were maintained by boards of health in other Southern states, including Mississippi, but the Talladega County records appear to be the only set of such cards that has been preserved.

Records of the Children's Bureau are also used to more fully understand the surveillance of childbirth and the regulation of midwife activities. Various publications of the Children's Bureau will be analyzed for visual representations of midwife education programs, particularly the changing image of the African-American midwife. A particularly useful series of Children's Bureau documents are the "Reports of Sheppard Towner Activities." These documents describe midwife education programs in each state where such programs existed. Almost every Southern state is included in the documentation, which is therefore helpful in understanding the scope of midwife education programs, as well as the particulars of each state.

I will also draw on letters received by and written by Children's Bureau staff during the time period covered in this study. The letters reflect the concerns of the various boards of health that were involved in midwife regulation. In particular, I will use letters concerning the founding and maintaining of the Tuskegee nurse–midwife training program. These letters reflect the position of the Children's Bureau regarding the short-lived program.

Oral accounts of traditional birth attendants are an invaluable source for this study. This study draws on published accounts, as well as unpublished oral interviews and notes of previous researchers. Oral accounts of midwives provide information regarding their religious ideologies and the common rituals of childbirth, as well as their experience under midwife regulation programs. Because there are few written records produced by African-American women lay midwives, oral accounts comprise an important resource for this study.

The history of child birthing practices and meaning in the United States has been the subject of several important studies in the history of medicine. Some of the most prominent works in the history of reproductive practices have dealt with the issue of professionalization. Charlotte Borst's 1995 study of midwives and physicians in Wisconsin is an extension of previous work done by Judith Walzer Leavitt in the field of the history of childbirth.⁵⁰ Borst builds on the work of Leavitt who was the first childbirth historian to argue that women played an active role in the transition from midwife to physician-assisted childbirth. Leavitt argued that women were drawn to aspects of modern science, particularly those that were intended to reduce the physical pain associated with labor, and that they were actively engaged in the process of professionalization. According to Leavitt's analysis, it was the move from home birth to hospital birth that finally

⁵⁰ Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920* (Cambridge, MA: Harvard University Press, 1995).

took decision-making power away from women, more so than the shift from female midwife to male physician.⁵¹

Borst, like Leavitt, is interested in the transition from midwife to physician-assisted childbirth among white women. Borst analyzes data sets from four representative counties in Wisconsin to examine the process of professionalization within the social context of Midwestern immigrant communities. She argues that “Issues of gender and culture have received much less attention, yet they are crucial for understanding childbearing families’ willingness to accept professional birth attendants in the early twentieth century.”⁵² Immigrant women were drawn to physicians who were familiar, that is, of a similar class, community, ethnicity, and geographic location as themselves and the midwives they replaced. *Male* physicians in immigrant communities could claim association with modern medicine and medical professionalism that female midwives could not.⁵³ Borst’s study ends in 1920 when the majority of childbearing immigrant women of the North had made the transition from midwife to physician.

African American women made the shift relatively late, and in a fractured way from midwife to medical professional. Unlike previous studies that have focused on white women of the urban North, I argue that among African-American women in the South, the transition from home to hospital birth was not a fluid one. It was staggered, complex, and difficult. Why were black women unwilling in some cases and not eager in most cases to turn to medical professionals and institutions, black as well as white, to deliver their babies? Why did Southern pregnant women continue to revere, trust, and depend on lay birth attendants? It is clear that African-American

⁵¹ Judith W. Leavitt, *Brought to Bed: Childbearing in America, 1750–1950* (New York: Oxford University Press, 1986). See also Wertz and Wertz, *Lying-In*. These authors trace the transition from midwife- to physician-assisted childbirth and focus on birth as a social event. Their objective is to understand why doctors in the United States sought to replace midwives earlier and to a greater degree than they did in Europe.

⁵² Borst, *Catching Babies*, 2.

⁵³ *Ibid.*, 119.

medical institutions had to wrestle these women away from midwives despite the growing knowledge gap between lay and professional attendants. Historian Darlene Clark Hine, in her history of African-American women in the nursing profession, has documented an example of such tension at the Flint-Goodrich Hospital in New Orleans. Hine describes hospital director Albert W. Dent's frustration when "during the first six months of operation, only fourteen babies were born at Flint-Goodridge Hospital, while midwives delivered 25 percent of all black babies." Hine notes that in the rural areas, midwives attended ten times as many women in delivery as black doctors.⁵⁴ Throughout this study, I focus on the role of religion and ritual in this negotiation of birth practices. Did the spiritual practices and divine associations of lay midwives make them more appealing to some women and less appealing to others?

In part, the answer to this question has to do with the economic crisis of Southern agricultural workers and the system of racial segregation, which fostered distrust of mainstream institutions among the working poor. However, I believe there is more to the story, which will illuminate the complexities of the lives of black women and the relationship among social programs, women's health, class identifications, and religion in the black South.

Other histories of childbirth and midwifery in the United States have focused on the decline of midwifery and have attempted to understand why lay birth attendants were forced out of their positions of power and authority as health-care providers. Chronologies of decline comprise the dominant model.⁵⁵ One of the first scholarly historical works that focused on the history of

⁵⁴ Hine, *Black Women in White*, 72. Keith Wailoo describes a similar example in Memphis. See Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina Press, 2001), 40.

⁵⁵ For studies that have charted and analyzed the decline in lay midwifery in the twentieth century, see Borst, *Catching Babies*; Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race and Memory* (Cambridge, MA: Harvard University Press, 1998); Francis E. Kobrin, "The American Midwife Controversy: A Crisis in Professionalization," *Bulletin of the History of Medicine* 40 (1966): 350---63; Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport, CT: Greenwood Press, 1978); Mathews, "Killing the

childbirth and the decline of female midwives in America is Judy Barrett Litoff's *American Midwives, 1860 to the Present*.⁵⁶ Litoff argues that the period of decline was most intense in the first several decades of the twentieth century. She presents an analysis of this decline and the social, economic, and medical factors that influenced it. She argues that the "growth of the medical professionalism and new discoveries in the field of obstetrics had ushered in the rudimentary stage of what would eventually become a heated and vociferous debate over the midwife's status in American society."⁵⁷ This debate reached its peak in the 1910s, and by the 1920s it had faded due to the shrinking numbers of active midwives.⁵⁸ As Litoff and others have recognized, by 1920 the majority of active lay midwives were African-American women in the South who were serving rural agricultural communities.⁵⁹

In her chapter titled "Forgotten Women," or midwives at the turn of the century, Litoff pays particular attention to the black midwives of the South. Litoff draws on several reports and medical journal articles to argue that while Southern black lay midwives were admired and preferred by poor black women, these midwives were poorly trained and inadequate health-care providers. Litoff compares the poor training of Southern midwives to their European counterparts, who were highly skilled and often trained in European midwifery schools.⁶⁰ While

Medical Self-Help Tradition among African Americans"; and Beatrice Bell Mongeau, Harvey Smith, and Ann Maney, "The 'Granny' Midwife: Changing Roles and Functions of a Folk Practitioner," *American Journal of Sociology* 66 (1961): 497---505.

⁵⁶ Litoff, *American Midwives, 1860 to the Present*.

⁵⁷ *Ibid.*, 21.

⁵⁸ *Ibid.*, 141. Litoff states that the height of the anti-midwife campaign was between 1910 and 1920 (*ibid.*, 82).

⁵⁹ Litoff, *American Midwives*; Borst, *Catching Babies*; Susan Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950* (Philadelphia: University of Pennsylvania Press, 1995); Holmes, "African American Midwives of the South."

⁶⁰ Litoff, *American Midwives*, 33. Litoff does not hold African-American lay midwives responsible for their inadequate training, and acknowledges that at least in the case of Mississippi they were in favor of more in-depth training. However, Litoff leaves the reader with the impression that European immigrants were the only "suitable" midwives at the turn of the century, with little analysis of the social, economic, and racial/ethnic factors that led to this education gap.

Litoff discusses the racial rhetoric of midwife opponents in a later section of the book, she does not apply it to her discussion of the insufficient training of black women in the South.

We must examine the presumption that lay midwives were in many cases “admired and preferred” by African-American women of the South, as Litoff mentions, and attempt to rediscover some of the complexities and textures that are flattened when the issues of race, class, and religion are not the primary focus. In order to do this, special attention should be paid to the 1930s and 1940s, a time period that has previously been overshadowed and referred to simply as the “period of rapid decline” in midwifery in the United States. Despite the reduced numbers of active lay midwives in the South, I will argue that African-American lay midwives continued to be a persistent and authoritative force in the experience of childbirth during the 1930s and 1940s.

When asked about their work, several midwives of Russell County, Alabama, who were “old and unable to read or write” stated that they had contemplated retirement but intended to wait until the Depression was over.⁶¹ This statement indicates that the economic and social challenges of the 1930s and 1940s influenced the decisions of African-American midwives regarding their profession. Many of them understood the importance of their work in communities that were largely untouched by modern medicine. Oral testimonies indicate that they had a strong sense that they were called by God to midwifery, and that if they resisted doing the work, harm would come to them.

The system of midwife regulation in the South has been the focus of several studies. Debra Ann Susie, in a study of midwife regulation work in Florida, adheres to the model of decline. Susie argues that the factors that led to the growing “unpopularity” of the midwife were the rise

⁶¹ Narrative Report of J.L. Dent, May 1934 (Alabama Department of Archives and History, Montgomery, AL [hereinafter ADAH], Bureau of Maternal and Child Health, Administrative Files, Box SG10367).

of industrialization and efforts to improve the professional standing of obstetrics.⁶² Susie traces the three phases of midwife regulation work—education, licensing, and elimination—as they played out in Florida.

Gertrude Jacinta Fraser, an anthropologist who uses some of the methods of historical inquiry, has studied the lives of African-American midwives in Virginia in the twentieth century. Like Litoff and Susie, Fraser is interested in the factors that led to the decline in midwifery. Fraser wants to understand why lay midwives, who were central to the experience of childbirth and the reproductive health of black women, were edged out of their practices.⁶³ Fraser's focus is on the interactions of race, gender, and midwifery. She argues that “[t]he writings and programs produced by physicians, nurses, and public health officials contained a universe of ideas about race and gender, the relationship of medicine to society, and the status of the South in the nation's political and social economies.”⁶⁴ Fraser uses the documents produced by medical professionals in Virginia and the oral interviews she conducted with retired midwives and the women they attended to analyze the discourses of race and reproduction. Fraser is particularly interested in the silences, that is, the issues these women would not discuss. Fraser found that the women she interviewed were particularly silent around issues relating to the time of labor and the rituals of postpartum care. She argues that these were the points at which “the use of folkways and ritual were most often incorporated into the birth process.”⁶⁵ One of Fraser's primary points is that “silence is inscribed in the history of midwives and birthing” in the

⁶² Susie, *In the Way of Our Grandmothers*, 2–3.

⁶³ Fraser, *African American Midwifery in the South*, 1.

⁶⁴ *Ibid.*, 2.

⁶⁵ *Ibid.*, 15.

African-American community she studied.⁶⁶ Fraser's notion of silence needs to be linked to the social, economic, and spiritual context of childbirth.

As historian Darlene Clarke Hine has shown, the culture of dissemblance among Southern black women was a method protecting aspects of their personal lives that were misunderstood in a culture of racial violence. Hine argues that "because of the interplay of racial animosity, class tensions, gender role differentiation, and regional economic variations, black women as a rule developed a politics of silence, and adhered to a cult of secrecy, a culture of dissemblance, to protect the sanctity of the inner aspects of their lives."⁶⁷ In the realm of childbirth, the culture of dissemblance was used to protect certain rituals that provided comfort to mothers and families. These rituals included such practices as the use of herbal teas during labor, placing a knife under the pillow to "cut the pain," and salting and burying the placenta, as well as reading certain passages of the Bible during a difficult delivery.⁶⁸ I discuss how the culture of dissemblance among African-American women was complicated in the case of midwives and childbearing women by an equally strong urge to improve their reproductive health and decrease the incidence of infant death. Midwives and mothers recognized that it was necessary to reveal some of the private aspects of home birth to medical professionals in order to gain health-care information. I pay particular attention to what aspects of the hidden world of childbirth were revealed and to whom.

⁶⁶ Ibid., 16.

⁶⁷ Darlene Clark Hine, "Rape and the Inner Lives of Black Women in the Middle West: Thoughts on the Culture of Dissemblance," *Signs* 14 (Summer 1989): 912---20. Historians of African-American women have often been faced with the issues of silence and disclosure. Alternative models of analysis have become necessary to understand the complexity of the lives of black women in America. See Evelyn Brooks Higginbotham, *Righteous Discontent: The Women's Movement in the Black Baptist Church, 1880-1920* (Cambridge, MA: Harvard University Press, 1993); Deborah Gray White, *Too Heavy a Load: Black Women in Defense of Themselves, 1894---1994* (New York: W.W. Norton & Company, 1999); Tera W. Hunter, *To 'Joy My Freedom: Southern Black Women's Lives and Labors after the Civil War* (Cambridge, MA: Harvard University Press, 1997).

⁶⁸ Smith and Holmes, *Listen to Me Good*.

Several previous studies closely analyze the relationships among race, class, gender, and medicine. Edward Beardsley's *A History of Neglect* deals effectively with issues of race and class within the context of Southern medical history.⁶⁹ Beardsley describes the health status and condition of two groups: African Americans and white mill workers. Beardsley analyzes the social and economic factors underlying the poor health of the two groups. The focus of his chapters on African Americans is the impact of racial segregation on the health care of Southern blacks. The issue of maternal and infant health care runs throughout the study. Beardsley discusses some aspects of the process of professionalization of childbirth in an incidental fashion. He notes, for example, that prenatal and infant clinics in South Carolina, North Carolina, and Georgia were frequented by black women at a higher rate than by white women. This was due to the midwife regulation laws in these states: Midwives were required to send their clients to be examined by a doctor in a clinic before the sixth month of pregnancy so that they could attend the birth. This increased the number of black maternity patients being seen by a physician in these states. These clinics were a "public substitute for private medicine," according to the author, and were reaching a sizable proportion of the black childbearing women of the South. These clinics also may have encouraged African-American women to seek further professional medical care during and after labor.⁷⁰ My study supports this conclusion, yet emphasizes that African-American midwives were enthusiastic in their support of the public clinic format. They were eager to bring their patients to see the physicians who ran them and in some cases provided their own homes as clinic venues, assisted the physicians, and brought multiple patients to see a physician at one time. It seems clear that while Southern, rural

⁶⁹ Edward Beardsley, *A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South* (Knoxville: University of Tennessee Press, 1987).

⁷⁰ *Ibid.*, 277.

African-American women maintained their preference to be attended by a midwife at the time of birth, they gradually became comfortable with the prenatal care that was being administered by physicians and nurses in the South. It was the act of birth that was surrounded in sacred mythology and therefore entrusted to the midwife. The period of gestation did not have the same ancestral significance and was thus entrusted to the physician with less hesitation. Furthermore, childbearing women trusted their midwives. If the midwife encouraged them to be seen by a physician, they were unlikely to go against her wishes. Most midwives did take advantage of the clinics, as Alan Brandt suggests; however, the documents used in this study reveal that the acceptance of prenatal care by midwives was spotty and depended on the personality of the individual midwife. Some adhered to the regulations, and others did not. Midwives were not uniform in their actions nor were there any clear patterns of acceptance. This study highlights the fractured nature of the process of professionalization of childbirth.

Historian Susan Smith has focused on the health-care work of African-American women in the South.⁷¹ Smith argues that health-care reform work in black communities was gendered in the sense that men were associated with formal leadership and national organizations and women were often involved in activism at the local level.⁷² She describes her book as a “full scale effort to examine the health reform initiatives created by African Americans themselves.”⁷³ The issues of race and class are integral to the analysis of health-care programs. The author argues that class identities influenced the nature of black middle-class, health reform work. The chapter on midwife regulation in Mississippi explores the ways in which lay midwives used the educational opportunities provided by health workers to improve the health conditions of their communities.

⁷¹ Smith, *Sick and Tired*.

⁷² *Ibid.*, 2.

⁷³ *Ibid.*, 12.

Smith describes the health-care work done by midwives in Mississippi, which went beyond the role of birth attendant. Building on the work of Smith and Beardsley, we must focus more on the transitions in childbirth practices in order to deepen our understanding of the intersections of race, class, gender, and medicine.

Linda Janet Holmes has collected numerous oral testimonies of midwives in Alabama. Her work is instrumental to the current project in that it captures the philosophies of midwives and presents a window into their health-care work. Holmes is primarily concerned with presenting the opinions of African-American women midwives, and has documented particularly well their spiritual beliefs and rituals that were incorporated in their work.⁷⁴ The oral testimonies collected by Holmes and others are used to gain greater insight into the belief systems and religious practices of midwives and mothers.

One way that we might continue to gain insight into the belief systems of African Americans is to focus on the rural areas of the South. African-American lay midwives and the mothers who depended on their services in these years were overwhelmingly rural agricultural workers. By using the history of childbirth as a focus, I intend to illuminate a broader understanding of the lives of predominantly poor women of the rural South, a social group that is complex and dynamic. When asked to state their occupation, the lay midwives of Talladega County responded that they were house workers, agricultural workers, and midwives.⁷⁵ Lay midwifery emerges as a significant occupation for Southern black women well into the twentieth century. It was an occupation that offered an emotional and physical respite from farm work, and also provided them with an alternative source of economic support. While midwives rarely received the five to ten dollars they charged for a birth, they received food and other forms of payment

⁷⁴ Holmes, "African American Midwives in the South," 275. See also Smith and Holmes, *Listen to Me Good*.

⁷⁵ Midwife Record Cards, Talladega County, ADAH.

from the families they delivered. In addition, midwives and mothers interacted with health education programs and sought new avenues for leadership. In many ways, midwives were the victims of their own participation in the maternal and infant health movements of the 1930s and 1940s. Their participation and the extent to which they guided mothers toward a more intimate relationship with modern medicine are some of the factors that led to the increase of physician-assisted childbirth. We must not romanticize the practice of midwifery or home birth, but rather explain the shifting meanings of midwifery and home birth within the context of racial segregation and economic hardship. Spirituality played in the experience of childbirth. Midwives and mothers navigated the terrain of modern medicine while keeping a firm hold on their religious beliefs and spiritual practices. We shall now begin to explore these issues in further depth.

Chapter Two:

Traditional Practices, the Spirituality of Childbirth

The good Lord taught me how to catch babies.... When I was catching babies I would pray for you. I would ask the Lord to help you and to help me take care of you. I've prayed so hard and my soul would be so full of joy.... I never used any instruments. I worked with doctors, I used herbs. I always gave new mothers ginger tea to keep their blood from clotting.

Traditional midwife in Wayne County, Georgia⁷⁶

The central characteristic of traditional midwifery among African-American women at the turn of the twentieth century was the intimate relationship midwives had with the spirit world. The experience of childbirth had a direct connection to an experience with God. African-American midwives often described the spiritual nature of their work when interviewed. The language of God intertwined the language of childbirth. They described themselves as “putting God ahead” and “taking the Lord into their insides” during a birth. Some midwives have described themselves as “knowing they were always blessed,” and “having much communication with the spirit.” Others knew they could “count on God to get to the birth before they did,” to “be the doctor,” and to “show them signs before a complication occurred.”⁷⁷ As the midwife quoted in the opening of this chapter from Wayne County, Georgia, tells it, “the good Lord,” taught her how to catch babies. Knowledge and technical information was revealed through a direct communication with God. Midwives believed they did not acquire their skills in this world, but were born with them. “God made me that way,” one woman claimed.⁷⁸ Their knowledge of the spirit world and direct communication with God was central to the maternal services they

⁷⁶ Litoff, *American Midwives, 1860 to Present*, 32.

⁷⁷ Smith and Holmes, *Listen To Me Good*, 84-5.

⁷⁸ Susie, *In the Way of Our Grandmothers*, 11.

provided to women in Southern communities. The spirituality of childbirth appears deeply interconnected with the traditional practices of African American midwives. They appear as almost indecipherable. This is intentional. The traditional practices of midwives, the rituals they learned from their ancestors, were dependant upon their spiritual beliefs. It is unlikely that they would have been maintained over any significant length of time if they were not. It is my assertion that the reason for their resilience amidst a climate of intolerance from the institutions of modern medicine is because at their core, they were spiritual practices and religious practices: stemming from folk religious beliefs, as well as the form of Christianity practiced by southern black communities in the first half of the twentieth century.

The practices described here are connected to a wider group of rituals and practices used by traditional birth attendants in many other parts of the world throughout the twentieth century. Some specific connections will be pointed out. For example, traditional midwives throughout the world have relied on the use of herbs and teas for healing purposes and to control complications during the birthing process. However, as Margaret Jolly has pointed out in her introduction to the book *Birthing in the Pacific*, we must be careful not to conflate “traditional” practices with “natural” ones. As she points out:

Before, during, and after birth the bodies of Pacific mothers were and are subject to indigenous interventions – albeit organic forms that relied on food, plants, and the hands of others to mould the maternal body. We have to see the pervasive stress on food and behavioural taboos for pregnant, parturient, and lactating women as cultural controls.⁷⁹

Thus there is a deep distinction between the traditional practices described here who have their basis in the spiritual beliefs of African Americans, and the practices used in the natural childbirth movement of the 1960’s and 1970’s. While there are some overlapping theories, such as the

⁷⁹ Margaret Jolly, “Introduction: Birthing Beyond the Confinements of Tradition and Modernity?” In V Lukere and M. Jolly ed. *Birthing in the Pacific* (Honolulu: University of Hawaii Press, 2002) p. 11-12.

preference of the standing and squatting position during labor, the natural childbirth movement is centered on the philosophy that childbirth is a natural process that is most successful with limited intervention.⁸⁰ African American midwives, along with other traditional childbirth attendants around the world, *intervened* in the experience of birth. They did so with traditional, spiritual, and medical techniques.

As the midwife from Wayne County described, prayer was fundamental to her work. She stated that she did not use any instruments. She most likely had limited access to medical instruments. She relied more on her spiritual knowledge than on medical procedures, yet she was not totally cut off from modern medicine. The midwives' relationship to the spirit world did not inhibit them from working within the medical community. As the traditional midwife further stated, she "worked with doctors" and "used herbs." The herbal remedies used by midwives were part of the traditional system of healing and connected to their spiritual beliefs. Their work with doctors allowed them access to certain medical techniques and supplies. During this time period (before state regulation of midwifery beginning in the 1920s), they seamlessly incorporated both into their practices. However, it was the direct communication with the spirit world and belief that they had acquired many of their techniques through a spiritual revelation that distinguished African-American midwives from any other health-care workers of their time.

In the areas of the deep South where midwives were most likely to practice during the first half of the twentieth century there existed an overlapping relationship between midwifery and general folk healing methods. Both systems were embedded with divinity. In an account from Miss Janey Bea, an African American folk healer, she describes the use of faith in her practice. "Healing has a lot to do with faith. Back in the olden days that's all they use was herbs and

⁸⁰ Sanda Vandam, M.S. Anderson, and Eleanor E. Bauwens, "An Ethnography of Home Birth." In M. A. Kay ed., *Anthropology of Human Birth* (Philadelphia: F.A. Davis Company, 1982) p. 290.

faith.”⁸¹ This statement echoes the one from the midwife at the opening of the chapter, which describes a synchronistic use of herbal teas and prayer in the birth room.

There were women in the South who were folk healers as well as midwives. They used their knowledge of herbs and healing for general ailments, particularly of children, as well as delivering women in childbirth. Granny Ya, is described by ethnologist, Wonda Fontenot, as a woman working “mostly as a folk doctor” who was once a full time midwife.⁸² “You see I was a midwife, and I been working on people, after I stop being a midwife.”⁸³ Granny Ya described her relationship to religion in this way: “This is a gift from God. I am a widow, I go to church every Sunday, and I ask the good Lord to help me with all their (patient’s) trouble.”⁸⁴ Her practice extended beyond the care of women in childbirth. “I put the red rag around them when I think they gon miscarry, and it hold the baby there. When child got asthma, or got attacke (overgrown liver), I put the red cloth on him and they okay.”⁸⁵ Granny Ya had a busy practice, she delivered approximately 100-200 babies a year during her active years. She was certified by her health department and occasionally worked alongside a doctor.⁸⁶ Yet she maintained a folk healing practice that was rooted in the traditions of rural Louisiana. These characteristics of maintaining an active religious faith, practicing folk medicine, and a partnership with modern medicine are recurring among African American midwives of the South during the first half of the twentieth century.

The spirituality of childbirth is rooted in the black experience in America. It has roots in the era of enslavement when the black woman midwife attended the majority of births, black as well

⁸¹ Wonda L. Fontenot, *Secret Doctors: Ethnomedicine of African Americans* (Westport: Bergin and Garvey, 1994), 56.

⁸² Fontenot, 53.

⁸³ Ibid.

⁸⁴ Fontenot, 54.

⁸⁵ Ibid.

⁸⁶ Ibid., 53.

as white, on the plantation.⁸⁷ The religious ideology of childbirth was syncretic, eclectic, and dynamic in the communities of the South. It reflected the history of black religion in America, and was shaped in part by the exclusion of black people from mainstream medical institutions. In his discussion of faith healing and the Pentecostal Church, Albert Raboteau describes the historical and societal factors that have contributed to the popularity of faith healing among African Americans.

Given the poverty of many black Americans and the high cost of medical care, given the cultural distance between black communities and predominately white medical facilities, given the lack of rapport between black patients and white medical professionals, it is not surprising that alternate forms of healing became important for Afro-Americans, especially in the days when black doctors were rare.⁸⁸

Alternate forms of healing were particularly crucial for the majority of Southern black childbearing women and for midwives who had few other options in the first half of the twentieth century. The religiosity of midwifery as articulated by midwives incorporated many elements of folk religious traditions, as well as an intimate relationship with a Christian God. This the central and dominant characteristic of traditional midwife work before statewide regulation began. Furthermore, the spiritual aspects of midwife work served a medical function that was considered crucial to the well-being of the mother and baby. The medical function of spiritually based rituals was doubted and maligned by medical professionals of the time. However, it was a deeply rooted, trusted, and culturally reinforced aspect of the experience of

⁸⁷ For a detailed description of the role of the midwife and black women's health work during the antebellum period, Sharla Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002). See also Deborah Gray White, *Ar'n't I a Woman? Female Slaves in the Plantation South* (New York: W.W. Norton & Company, 1985).

⁸⁸ Albert J. Raboteau, "The Afro-American Traditions," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen (Baltimore: Johns Hopkins University Press, 1998).

childbirth for Southern black women in the first several decades of the twentieth century and beyond.

There existed in the black South a common spiritual language and practice of childbirth that united midwives and mothers in a loose sisterhood, and identified them as a communal body of spiritual practitioners. Their language of God was not unique; it was derived from the wider evangelical and folk practices of the South. However, the application of this language to a medical purpose and a feminine physical event was discordant with the goals of modern medicine and the emerging field of obstetrics.

African-American women of the South who became midwives believed they were called by God to do so. The decision to become a midwife was not believed to have been made by the individual women, or by their predecessors, but by God. Most accounts of traditional African-American midwives include a description of some form of calling such as the following:

I was plowing in the field, plowing cotton, when a voice within told me he wanted me to be a midwife, to take care of mothers and babies. The Lord showed me just how it was to be done, I seen I was in a tall fence and my mother was standing on the outside with her arms folded.

When the Lord talk to you, he talk so that you can understand. These cows was young heifers and they was all expecting to deliver calves. I was in the pen, how I got in there I couldn't tell you. All at once the calf come from the cow. All of a sudden a little boy, he was about that high [two and a half feet], run to the calf and showed me just how to tie the cord here, and then here, and cut in between. Then I woke up in the cotton field.⁸⁹

This account incorporates many tenets of the traditional midwife philosophy. The first is that it indicates that the decision for this particular woman to become a midwife came from “the Lord.” The midwife described it as being “all in the plans of God, it was nothing on my part.”⁹⁰ In this vision, God is instructing the woman to be a midwife through a demonstration of how to cut and

⁸⁹ Dougherty, “Southern Lay Midwives as Ritual Specialists,” 153. The passage is taken from an oral interview conducted by the author with a traditional midwife in northern Florida

⁹⁰ Ibid.

tie the umbilical cord of a newborn, which he demonstrates on a calf. Midwives believed that their knowledge and skills in health work, and even technical procedures such as tying the umbilical cord, came to them directly from “the Lord,” or from “doctor Jesus.” The information appeared to her in a format that was simple and direct. As the woman described it, “[w]hen the Lord talk to you, he talk so that you can understand.”⁹¹ This was a common experience. The communications they received from the spirit world were always direct and simple. They were occasionally forceful and overpowering. But they were always easily and immediately understood.

The woman stated that after having the vision she knew she was being called to be a midwife, yet she pushed the knowledge aside and did not tell anyone about it. She recounted that she repeatedly heard the words in her head, “Why don’t you tell it?” and understood that she was being further pushed to enter the life of the midwife. Eventually she acknowledged the vision and embarked on her career at the age of fifty-five.⁹²

Another midwife described the calling she received through her predecessor. The elder woman had received a sign that it was time for her to pass along her knowledge to a younger woman who would take over her position. “I’m getting old and I done been on this journey for forty-five years. I am tired. I won’t give it up until the Lord replace me with someone. When I asked the Lord, he showed me you.’ The midwife initially resisted. She told her elder, ‘U-uh, Aunt Minnie, The Lord didn’t show you me.’ The elder midwife responded by saying, “yes, sir, you got to serve. You can’t get from under it.”⁹³ The elder midwife described to her protégé that once an apprentice had been revealed through divine communication, there was no way to

⁹¹ Ibid.

⁹² Ibid.

⁹³ Ibid.

resist or ignore the calling. During her midwife training, the apprentice often felt fearful and anxious about her new position. She was unsure about her ability to perform under pressure, but certain that she had little choice in whether to accept her calling.

The emotions of fear and reluctance are common in accounts of one who has been called to be a midwife. The women recognized that midwifery was a spiritual path that was heavy with responsibility. The position of midwife was heavy because midwives often were faced with life and death decisions. Experienced midwives were familiar with pain, suffering, and loss of life. African-American women of the South recognized in the first half of the twentieth century that the experience of childbirth could be a physically dangerous event. There were many common ailments and complications associated with childbirth at the time. When a woman was in the stages of labor, she was considered to be in a shadowy place somewhere between life and death. The midwife was the guide on such journey, which came close to the experience of death. She might witness the death of a mother or infant during her time as midwife. For this reason, many young recruits were fearful and anxious about their positions. In her testimony, Margaret Charles Smith relates several reasons for her reluctance to become a midwife in rural Alabama. The first had to do with the difficult conditions that midwives had to endure in their practices.

I didn't want to be a midwife, I didn't want to because I saw what Miss Ella Anderson had to go through with, and how she had to travel. Transportation was something scarce here. When you see a car, that was a big thing. Me and her would get out at night...It was horse, buggy, mule or buggy, or wagon, and I rode in many of one of them at night, going through the waters, snow and ice.⁹⁴

⁹⁴ Margaret Charles Smith and Linda Janet Holmes, *Listen To Me Good: The Life Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996), 71.

Margaret Smith had already had several experiences assisting an elder midwife, Ella Anderson, but once she had become certified and taken the midwife oath, she was asked to deliver a stillborn baby. The local doctor who had recommended her asked her to go to the delivery.

I know he saw my complexion change when he said, “He’s going to be dead.”

Then the doctor told me, “All you got to do is go there and wait till the baby comes. That’s all you got to do, and bring the birth certificate by me.”

I said, “Yes sir,” but I like to die.

Then he told me, “You got to dress him.”

That’s when I said, “I’m sorry, but I can’t do that.”⁹⁵

The doctor continued to urge her, and Margaret Smith finally agreed to deliver the baby.

When the baby come, I was sweating just big drops of sweat, trying to bathe this baby – put the baby on the quilt. You could look up in that house and see the stars. The wind was blowing, but that was all right ‘cause I was still dropping big beads of sweat.⁹⁶

Despite fears and the sense of being burdened, most women chose to accept the midwife calling. Many women felt that they were “motivated by forces beyond themselves and that it would be dangerous to them to ignore the signs they sense and feel.”⁹⁷ One woman from Alabama claimed that when she attempted to resist her calling to become a midwife she became sick. “After I didn’t do that at that time he showed me, I got down sick, but didn’t no where hurt me. So I told Him, if that what He had for me to do, I would do it. I got just as healthy as if I were a child.”⁹⁸ According to the elder midwives, a woman was not qualified to practice unless she had received a calling and had become familiar with the spiritual aspects of the work. Even Margaret Smith who had just delivered her first baby by herself, a stillborn, had to face the

⁹⁵ Ibid., 79-80.

⁹⁶ Ibid., 80.

⁹⁷ Dougherty, 153.

⁹⁸ Holmes, “African American Midwives of the South,” 279.

charge that she was willed by forces outside of herself to practice from an of elder of the family she had attended.

I said, “Tip, I tell you, I done made a great mistake in life.”

She said, “No you ain’t. You doing what the Lord wants you to do. Now if you weren’t doing what the Lord wanted you to do, you wouldn’t have knowledge enough to do it. You didn’t do this on your own – the Lord willed this, for you to do this kind of work and try to make the best of it you can...”⁹⁹

It became clear to Smith and others in her position, that she was led to the work of midwife by divine forces. She had been urged to practice by the local doctor and her predecessor Ms. Anderson as well. But it is clear that she believed the ultimate force to be divine.

Traditional birth attendants in Guatemala share some similarities with the accounts of traditional black midwives of the South. Mayan midwives believe they have a spiritual calling to practice midwifery. They receive messages from the spirit world and from God that this is their destiny and negative consequences may occur if they do not follow this calling.

This destiny of *mandado* is revealed in various ways, such as birth signs (being born with a veil or on a certain day), repetitive dreams, finding strange objects (shells, scissors, mirrors, special shaped stones), and serious illness. These are considered messages sent by God or the spirits, and are interpreted by a shaman as indicating the midwife’s calling. If she does not follow her destiny, she shall be subject to supernatural sanctions which may take the form of worse illness or death for herself or members of her family.¹⁰⁰

Mayan midwives receive training through a similar apprentice like relationship with an elder midwife. She may be a female relative such as mother or grandmother. Like African American midwives of the South, they believe that their knowledge of how to assist a woman during birth

⁹⁹ Smith, 81.

¹⁰⁰ Sheila Cosminsky, “Knowledge and Body Concepts of Guatemalan Midwives.” In *Anthropology of Human Birth*. M. A. Kay ed. (Philadelphia: F.A. Davis Company, 1992), 237.

comes from a divine source as well as the practical experience they receive through the apprenticeship.¹⁰¹

According to the traditional system of succession among African American midwives of the South, a senior midwife was responsible for choosing her successor. The younger recruit typically was a member of her family, usually a daughter or granddaughter. Occasionally the woman chosen was not a member of her immediate family. She may have been another woman from her community who had been shown to her in a vision, or who herself had received a calling through a dream or vision.

The young apprentice was gradually introduced to the work by performing some of the mundane tasks of midwife work, such as cleaning the home of an expectant mother or doing the laundry. Gradually she was taught the rituals associated with childbirth. The apprentice learned that there were rituals associated with the burial of the placenta, or that dried pieces of the baby's umbilical cord were to be burned in the stove. An apprentice could be asked to bake little pieces of linen for cord dressings in the oven until they were browned, then ironed the larger pieces that her elder would use at the bedside of a woman in childbirth.¹⁰² These tasks seem minor, yet they were part of a body of knowledge that was considered necessary by the community elders for full consideration of midwife work.

Young trainees become familiar to the wider community as one who would one day stand on her own as a practitioner. Most recruits continued to follow the elder women to births until one day when called to attend a birth on their own. The apprentice would be called to go in her place, or in some cases the baby would arrive before the senior elder midwife. It would have been very difficult for women, trained or not, to refuse such a request. Even if she had been

¹⁰¹ Ibid.

¹⁰² Mongeau, Smith, and Maney, "The 'Granny' Midwife," 502.

resisting formally entering the craft until this point, once she had attended a woman on her own, the pressure to formally enter the occupation was great.¹⁰³ By then she would have built up a level of trust with the people of her community. The process was usually gradual, and sometimes would span the childhood and young adulthood of women who were identified early as successors to the tradition. The following account describes the gradual nature of the traditional apprenticeship:

My mother was a midwife. There have been practicing midwives in my family for nigh on a hundred and fifty years.... My mother was a good midwife.... From a little girl she used to send me out to tend the mother and baby and take care of the cord.... She wouldn't take me on a delivery, said it was time enough when I got married.... When I became pregnant my mother delivered my first baby, and after that she started taking me on deliveries with her and sometimes with the doctor. After a while she would send me out by myself. I finally ended up delivering about all of them except those who wanted her special.¹⁰⁴

Margaret Smith describes the way that she was introduced to midwife work. Initially she was called to help her cousin's wife who lived near her and had thirteen children. "I being right there, she would come out – wasn't any pine trees or nothing growing there – she would come out and call me, and I could hear her. She'd tell me to come there, and I'd go. Every time she would have a baby, I'd be there."¹⁰⁵ She said she had to go to her because the Lord wanted her to help the needy, and this woman was in need. She did not have any one else to be with her during her births.¹⁰⁶ Smith's experiences with her cousin's wife prompted Ella Anderson the local elder midwife to urge her to become a formal midwife. "Miss Ella says, 'Uh, Margaret,

¹⁰³ Susie, *In the Way of Our Grandmothers*, 11.

¹⁰⁴ Testimony of midwife, in Mongeau, "The 'Granny' Midwives,": 59.

¹⁰⁵ Smith, 68-9.

¹⁰⁶ *Ibid.*, 70.

why don't you be a midwife? 'I say, 'No Lord, un-uh. I'm not going to be a midwife.' But she just kept a-worrying me, every time."¹⁰⁷

Smith was urged by Anderson and the local physician to become a licensed midwife. She had delivered six of the twelve children born to one brother in law and half of the thirteen of another. In some of these cases the midwife, Ella Anderson was called, but the child had been born before she arrived. "When Miss Ella Anderson come, I be done got the baby. You know, got me a string and tied the cord to keep the blood running out the baby."¹⁰⁸ However, there was one case where the woman experienced more than the usual amount of bleeding. Smith urged the family to call the doctor of midwife. She told the husband that his wife was bleeding too much. Initially he responded that, "probably that just gonna be." Smith replied, "No, I don't think it is." And she ran to call the doctor who saved the woman's life. It was after this experience that he urged her to become a licensed midwife.

"That's when the doctor said, "why don't you go and be a midwife?"

I said, 'No sir. I don't want to be a midwife. I can't be none. No sir, nobody's going to turn me into a midwife.'

He said, "Well, I am."¹⁰⁹

Although Smith already had significant experience assisting women she did not consider herself, nor did she welcome the idea of being an official midwife, licensed by the state. It was through the urging of other more experienced health workers in her community that she embarked on a career as state sanctioned midwife, and began to develop a wider following of her own.

Claudine Curry Smith followed a very similar path to midwifery. Like Margaret Smith, Curry Smith was summoned to assist women in labor before she had begun her official training

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

¹⁰⁹ Smith, 71.

to be a midwife. It was usually the women in her surrounding community who called on her while they waited for the “official” midwife.

People used to call me to come when they went into labor. I’d go and talk to them, so they wouldn’t get too excited before the midwife came. Like a cousin of James, she was pregnant, her mother called for me to come. They were waiting for Miss Lou, but when I got there, the baby had been born and rolled under the bed. I picked it up and got things straightened out ‘til Miss Lou got there. This was five years or so before I became a midwife.¹¹⁰

It was after she had this type of experience that she was also urged by others to continue with the work in a more official fashion.

I never thought about becoming a midwife until Miss Carrie B. Smith came by my house and she told me, she say, ‘Claudine, I’m getting too old and they always calling me, why don’t you become a midwife?’

I said, ‘No, I don’t think I can do that, I don’t think so.’

She say, ‘Yes you can,’

And I say, ‘Well I don’t know.’ In the meantime she kept after me and then she talked to the county nurse and the county nurse, Miss Theodosia Campbell, came by three times before I gave her an answer.

And I say, ‘maybe I’ll try it.’¹¹¹

The county nurse gave Curry Smith her first instructions. She told her that all she had to do was to go to the health department and learn the instructions for being a midwife. After she had her third delivery under the guidance of the health department she would be given her midwife bag and the things that she was to carry with her to a birth. “You had to learn the rules like you was going to school. Then you went through the motions, like washing your

¹¹⁰ Claudine Curry Smith and Mildred H. B. Roberson, *My bag Was Always Packed: The Life and Times of a Virginia Midwife* (Bloomington: 1st Books, 2003), 35.

¹¹¹ Smith and Roberson, 52.

hands and weighing the baby they had a baby doll and tying the cord and all that and if you did OK you get a license.”¹¹²

It was common for a woman to be ready for her own practice only after she had become a mother herself. The following is the account of Claudine Curry Smith from her life as a midwife and mother in rural Virginia:

After the baby was born, James and I rented my grandfather’s brother’s house just up the road, a year and a half later our second child, Shirley Jane was born. When James’s home place up in Remo was available, we moved up there, we still didn’t have electricity or running water, but we didn’t have to pay rent. Our third child, Sheila Jeanette, was born in January 1939. In between babies I worked at the tomato factory peeling tomatoes or at the fish factory cutting and packing fish. Eighteen months, the fourth child, Geraldine Oletha, was born, and I was doing some domestic work at that time. Three years later the fifth child, James A. Jr., was born. These first five children were all born at home with a midwife.¹¹³

The first midwife who delivered Curry Smith was a relative. She describes the way her choice of midwife and the circumstances of her birth evolved naturally from the conditions she was living under and her social relationships.

My first midwife, Rose Curry, was my father’s aunt and I just asked her if she would come when I was being delivered. But see I knew her permanent cause she was my aunt. And she went to the same church. She had had 12 children herself. And we talked at different times and she told me what to have, you know, like the baby clothes and some old sheets and old clean white pillowcases, things like that, and plenty of newspapers.¹¹⁴

I was still living in my grandmother’s house and we didn’t have any running water or electricity. But my grandmother had the water and everything ready for Aunt Rose. She just lived up the road. Somebody went for her on horseback and she came down in her horse and buggy.¹¹⁵

¹¹² Ibid.

¹¹³ Ibid., 12.

¹¹⁴ Smith and Roberson, 29.

¹¹⁵ Ibid., 30.

In addition to having had one or more children themselves, many women had been following an elder midwife for some time before developing their own practice. This was the case with Margaret Smith. Catherine, a midwife in North Carolina, describes her entry into midwife work. She had wanted to follow and learn from her grandmother who was a midwife, but her mother was already training to follow her. “She knew I had the ‘call’. I kept after her but she wouldn’t let me go.”¹¹⁶ Finally, she asked a local doctor, Dr. Walker, if she could take over for an elderly midwife, Jenny Grace. Another woman had already planned to take over for her, “but Dr. Walker said it was all right and there was enough for two. I followed her until she gave up and then I followed Dr. Walker. After my mother gave up, Dr. Walker and I delivered as high as 300 babies in one year.”¹¹⁷ Another midwife from North Carolina by the name of Elizabeth worked with several doctors, the last of which was “young Dr. Baltmer.... I followed him until they retired me.”¹¹⁸

Not all midwives were mothers. In the example of Aunt Belle, a midwife who practiced in rural Georgia in the 1940’s, she learned that she could heal her pain of not becoming a mother through working as a midwife. The local physician, Doc Powell, told her that, “some women are not made to have babies. But I tell you how you can ease your heart about babies. I’m getting old and I need help with my baby cases.”¹¹⁹ Aunt Belle responded that she was under the impression that midwives were often old, and she was not, and that midwives were often called by the Lord, and she had not yet been. Doc Powell instructed her to, “get things fixed up with the Lord,” and he would check with her later.

After some consideration and prayer, Aunt Belle agreed to undergo training with Doc Powell.

¹¹⁶ Mongeau, 59.

¹¹⁷ Ibid.

¹¹⁸ Ibid., 60.

¹¹⁹ Marie Campbell, *Folks Do Get Born* (New York: Garland Publishing), 1946. P. 108.

So I went with old Doc the next time he got sent for by a woman in her misery. I tended with him and he told me and showed me what to do. After that I tended with him a lots of times. Then come a day when he said, 'Belle, you could do this by yourself when it's not a hard case. I'm old and I can't be every place.'¹²⁰

As mentioned previously, midwife recruits often learned techniques from an elder midwife as well as from working with the local doctor.

I started in 1908 but not in real practice until 1918 when my grandmother, Mary Lynch, gave up. She said I was the only one to follow her and she taught me. In the old days I followed Dr. Borman, my grandmother[']s doctor, and when he died I followed Dr. Chalmer who took his place. I went with him on all of his deliveries. I stayed with his quality patients and when I left, the babies didn't know their mothers.¹²¹

Before the state-run intervention programs of the 1920s, in the Southern states a close relationship between local physician and midwife was common. As noted in the previous testimony, the black midwife watched and learned from the doctor. She "followed" him, a term that refers to the practice of assisting the doctor. After a period of training, she was often responsible for his white patients, and only called for him when an emergency arose. She did everything necessary for her white patients. The midwife stated in the previous quote that when she left her white patients, the babies "didn't know their mothers." This statement implies that she took on the majority of the infant care. She likely did this for her black patients as well.

In almost all respects, however, the care given to white and black women differed. Relatives, neighbors and other women in her community were familiar with the traditional practices of the midwife. White women were not familiar with the folk rituals. There was no ancestral link for the white women, a key factor in the power and trust relationships between midwives and women in their own communities. This fact demonstrates the adaptability and creative nature of

¹²⁰ Campbell, 109.

¹²¹ Mongeau, 58.

midwife practice. The midwives were able to mold their practices according to the patients they served, depending on the background of the patient and her comfort level with modern medicine. They had the knowledge and ability to do this, as well as the freedom to do so before the most intense phase of regulation in the 1920s.

Traditional midwives were very busy in the first decades of the twentieth century. They often had large families of their own and women such as Claudine Smith worked in several occupations in addition to midwife work. As mentioned in a previous quote, Claudine worked in between her children in a tomato factory, a fish factory and in domestic work. She did this in addition to caring for her own home, family farm, and children. While working as a midwife she drove a school bus and worked as a care taker for elderly people in her community. She describes work as being a regular part of her life, and something that she did right up until giving birth during her childbearing years.

Once you knew you were pregnant you contacted a midwife and she's tell you what you'd need to have at home. But you didn't call on her until you started in labor. And you kept on working. If you were doing heavy work, you might stop a couple months before, but you kept on doing housework until the baby came.¹²²

In terms of health work midwives of the South often performed several duties as well. They performed some tasks for the white doctor and kept up with the needs of their own communities as well. Catherine, a midwife quoted earlier, describes her busy practice: "After my mother gave up, Dr. Walker and I delivered as high as 300 babies in one year. Sometimes I helped him, but most of the times he told me to go ahead and he would come if I needed him."¹²³ Another midwife by the name of Elizabeth describes a similar experience. She followed a doctor, Dr. Baltmer, and also had a large practice among the African-American women of her community.

¹²² Smith and Roberson, 27.

¹²³ Mongeau, 58.

She called the doctor when she needed him, and according to the testimony given, he knew that “Elizabeth knew what she was about and he didn’t tarry.”¹²⁴ In other words, if she requested his presence, he knew that there must be a pressing medical emergency and he should get to the birth as soon as possible. Midwives became experienced enough to recognize the limits of their expertise, that is, the circumstances in which the doctor’s knowledge was necessary. Traditional midwives developed a mutually beneficial relationship with the local white doctor so that he believed he would called only when his services were absolutely necessary to save the life of the expectant mother and baby. Elizabeth claimed in her testimony that “she was a midwife and she also followed the doctor,” and she learned to do both types of practices from her grandmother and great grandmother who were midwives. She did not credit the doctors she worked with for her learning and ability to practice midwifery. She described “midwifery” as what she practiced when she went into the homes of clients from her community who had engaged her to deliver them. “Following the doctor” is what she practiced when she went into the homes of white clients who were also being seen by the doctor. She made it clear that she never “followed” the doctor into a home of a nonwhite client. In that instance, it was “he who followed her.”¹²⁵

The doctor, who was also very busy, was not always able to answer the call of a midwife during an emergency. A midwife by the name of Anna had to be decisive during a difficult situation:

Once I had a patient who couldn’t deliver the afterbirth. I sent for Dr. Anderson but he was out on a case and they couldn’t find him. So I got some black pepper and set it on fire and put it under her nose. She started with such sneezing fits that I thought I had killed her, but she sneezed out the afterbirth.¹²⁶

¹²⁴ Mongeau, 60.

¹²⁵ Mongeau, 61.

¹²⁶ *Ibid.*, 56-57. An account of traditional birth attendants in Nigeria describes the practice of inducing a woman with a retained placenta to sneeze. A bitter pepper is put in a fire near the woman in labor. The smell causes the woman to sneeze vigorously, and the placenta is expelled. See, Yvonne Lefebvre and Henk Voorhoeve, *Indigenous*

Had the doctor arrived, Anna's choices may have been different, but when forced to handle emergency situations on their own, midwives such as Anna trusted their traditional resources and did the best they could for their mothers, employing equal parts folk remedy, prayer, and medical knowledge. The delivery of a retained placenta was one that frequently arose. Other emergencies that midwives frequently dealt with were hemorrhage, breech presentations, and the delivery of twins or triplets. African-American midwives did what they could for their clients during these situations, but gave God the credit for all successful outcomes.

During this time when midwives enjoyed a working relationship with the local doctor, their practices were dynamic and evolved alongside changing medical practices of the time. They usually used a combination of techniques, depending on what they had been told by the doctor they worked with and what their intuition and experience told them. Medical techniques and supplies did not overshadow traditional rituals, but were worked in combination according to the discretion of the particular midwife. The testimony of midwife Catherine provides a good example of such decision making:

Aunt Minnie used lard on the cord, but Dr. Walker said boric acid was better. Aunt Minnie used pepper tea to stop the bleeding which was good, but I also used ergot which is good too. Dr. Walker told me to give them that and to give the baby paregoric if it was restless and cried too much, and to give the mother a good dose too the first night.¹²⁷

Contradictory information was not a stumbling block for most midwives. They received and incorporated all information equally. Another midwife describes the contradictions between the

Customs in Childbirth and Child Care (Assen, The Netherlands: Van Gorcum), 1998. P. 32. Other accounts describe asking the mother to blow vigorously into a bottle, or inducing the woman to vomit by putting garlic or hair into her mouth in order to expel the placenta. Lefeber and Voorhoeve, 31.

¹²⁷ Mongeau, 59.

information she learned from her predecessor and that which she learned from the doctor she worked with.

To make labor short, my mother said it was good to put feathers in the chamber pot and then set the mother on the pot. My mother also told me to salt the afterbirth and bury it deep so the mother wouldn't hemorrhage. But Dr. Anderson said that didn't do no good and he gave me ergot to use.¹²⁸

Midwives such as this one may have abandoned some techniques in favor of the doctor's remedies, but overall the lessons learned from their predecessors were not forgotten and were used at the midwife's discretion. This fact distinguishes turn-of-the-century practices from the later ones of midwife regulation, when major attempts were made to force midwives to abandon traditional practices. The way in which midwives combined traditional and medical practices was also unique for the midwives of this time period. Some women seemed to know that they used multiple techniques for the same purpose, such as the ergot given them by the doctor, and pepper tea, which was the traditional practice. There is no indication that one was trusted over another or that one was believed to have more medical validity among the midwives and mothers. Midwives trusted the doctors they worked with and followed their instructions without abandoning their own practices.

For instance, the midwife Elizabeth worked closely with Dr. Baltmer, and followed his advice:

She carried ergot in her bag which she gave as Dr. Baltmer said, "a big teaspoonful as soon as the afterbirth slips out." She also carried in her bag tansy tea which was "strengthening" and pepper for making tea which was "good for bleeding." The ergot was for the same purpose and she seemed to know this was so, but she gave them both. She always carried toothache medicine (oil of cloves) because "one never knew." Camphor was another

¹²⁸ Ibid., 65.

necessity—the doctor said it was good for “fevered breasts” and she also gave some aspirin which the doctor said was good for afterbirth pains.¹²⁹

It is clear that Elizabeth learned a lot from the physician. Yet she maintained her right to hide certain practices of her own from him and his clients. The doctor knew that she had her own set of practices, but did not know exactly what she did with her own patients behind closed doors. “They all practice some sort of voodoo,” he told his interviewer. “They won’t tell you but they do. Elizabeth never told me, and she won’t tell you either.” Despite the close working relationship Elizabeth shared with the doctor she “followed,” she never divulged to him the practices she used in her traditional midwife work. She maintained the veil of secrecy with respect to her spirit-based rituals, and the intimate nature of the birth experience she shared with her black clients. This may have been part of the reason that African-American women trusted their midwives so deeply. They shared a circle of privacy and trust behind the racial veil.

This particular midwife learned a variety of techniques from her doctor. On one occasion, she administered chloroform to one of her patients, so that he could extract the baby using forceps. Unlike her white patients, this woman resisted taking the pain-relieving drug. She may have felt that it was invasive or foreign. Unlike other medical techniques that were incorporated into the traditional practices of midwives, chloroform drastically altered the experience of childbirth. The communities of women who relied on African-American midwives strongly preferred traditional methods of easing the pain of childbirth, and resisted abandoning them until the last half of the twentieth century.

There were some people in the South who held a false belief that African American women were immune to the pain of childbirth. Therefore, they did not need the same types of pain

¹²⁹ Ibid, 61.

medications frequently prescribed to white women. A physician who worked with Claudine Smith in Virginia in the 1950's stated that, "I don't think the colored population really has as much pain – the more sophisticated you get the more educated you get and the more you read, the more you worry and the more pain you have. But they don't worry as much and they consider childbirth is a natural phenomenon."¹³⁰ In contrast, he described the regular use of chloroform with his white patients. "We'd saturate a wad of cotton with Chloroform, give it to the mother and she'd hold it over her nose and it worked real fast, two or three whiffs."¹³¹

The use of chloroform for African American women in childbirth is typically described as an exceptional case. For example, a condition that presented some potential danger for the mother or child. In the preceding example of midwife Elizabeth she recognized that it was necessary for one woman who had "lingered and lingered," or whose labor had stalled, to have chloroform administered so that the doctor could remove the baby.¹³² The doctor who claimed to believe that African American women were immune to the pain of childbirth stated that he would use pain medication when a complicated case arose.

If I got called out the help 'em and we got in a tight place and I had to mix something for some painful thing like episiotomies or forceps deliveries, I'd give 'em a little Demerol and Scopolamine and a little Chloroform. But most deliveries were normal and there was no need for medication.¹³³

Physicians in the South provided instructions to rural midwives in other common procedures related to childbirth. These procedures were intermixed with common rituals associated with traditional systems of healing. The secret doctors of Louisiana have been similarly described as

¹³⁰ Smith and Roberson, 73.

¹³¹ Ibid., 72.

¹³² Ibid.

¹³³ Ibid., 73.

a “syncretic tradition,” and one that is “based on the integration of several cultural traditions.”¹³⁴ Ethnologist Wonda Fontenot describes that, “when Africans arrived in the New World they adapted certain principles and incorporated certain techniques into secret doctoring to deify its true character and more importantly assure its survival.”¹³⁵ Similarly, the African American midwives of the twentieth century were continually adapting their practices according to the transitions of modern medicine and their access to new materials, skills and theories of childbirth. According to ethnographer Beatrice Mongeau, “the reputable midwife of indigenous origins considered herself a colleague of a particular doctor.”¹³⁶ It was through this relationship that the traditional midwife added to her knowledge and abandoned or altered her previous practices. Some midwives, according to Mongeau, were proud that they no longer used certain outdated items such as pig lard for umbilical cord dressings, and had switched to using a piece of linen sprinkled with flour and baked brown. This practice was later abandoned as well when the local doctors began to use boric acid and made it possible for the midwives to use it as well. As mentioned previously, medical and traditional practices were often used in combination.

If she learned from him an effective method for expressing the placenta, she no longer set her patient on a pot of hen feathers.... [S]he continued to slip the ax under the bed to cut the pain, and she tied thin copper wires of cords high on the thighs to keep the pains in the abdomen from slipping down the legs. Sometimes to make double sure of success, she used the doctor’s technique and threw in her own for good measure.¹³⁷

The doctor who worked with the midwife, Elizabeth, in another example, provided her with instruction in how to ensure that the entire placenta had been delivered by piecing it together after it had been expelled. She accepted the instruction of the physician, yet she did not abandon

¹³⁴ Fontenot, 44.

¹³⁵ Ibid.

¹³⁶ Mongeau, Smith, and Maney, “The ‘Granny’ Midwife.”

¹³⁷ Ibid.

the traditional practice of burying the placenta deep in the ground as instructed by her midwife predecessors. She had been told that the hole must be at least eighteen inches deep, and that if a dog or other animal got hold of it, the mother would become sterile.¹³⁸ Elizabeth's acceptance of the physician's instruction did not inhibit her traditional beliefs. Disposal of the afterbirth was considered one of the midwife's greatest responsibilities. There was a practical side of the burial rituals, but their primary significance for the women lay in their spiritual meaning. There was a common set of techniques that involved burial, but each midwife added her own ancestral line of practices. "One midwife, after wrapping the placenta, tied it with 'exactly nine knots' while another 'never let it on the floor.' Most of them planted it in the ground an exact number of inches and did, or supervised, the digging themselves. It was considered part of the body to be interred with the same respect as the body proper." The true spiritual and theological meaning of these rituals is difficult to determine. A woman who was part of a long line of secret doctors in Louisiana describes the use of nine knots such as in the above account. "Back in the olden days that's all they use was herbs and faith. My aunt use to treat with nine knots (on string) and nine prayers."¹³⁹ There is a continuity of practice and belief that runs through these rituals. What is clear is that they are linked to ancestral practices, and that their foundation is faith and connection to spirituality and the Bible. The Louisiana woman who described the use of "nine knots," went on to say that she also incorporates a prayer that she says to herself nine times. "The prayer it's nothing superstitious, voodoo or nothing, just prayer, plain prayer. You stop and you think and you read the Bible back then Jesus give people power to go out and heal people, and it was with prayers and it's nothing but prayers."¹⁴⁰

¹³⁸ Smith and Roberson, 72.

¹³⁹ Fontenot, 56.

¹⁴⁰ Ibid.

Accounts of traditional birth attendants from other parts of the world often include a similar description of the burial of the placenta after the birth of a baby. This was in most cases the responsibility of the midwife or a female relative. Among the Seri Indians of Mexico, it was traditional for an elder woman, often the maternal grandmother of the infant to salt and bury the placenta near the base of a cactus. In more recent times the placenta is often buried outside the village. “Five small plants of any species are buried with it. Ashes are put on top of the place of burial to keep the coyotes from locating it.”¹⁴¹ African women of Zaire (formerly known as the Belgian Congo) avoided giving birth in a certain maternity clinic in the 1920’s because they were not able to control the disposal of the placenta.

Some Kaguru men and women refused to have their babies born in Native Authority maternity clinics in Tanganyika because afterbirths were not turned over to the parturient’s kin for disposal; they feared hospital attendants might bewitch mother and child. Likewise, the clinic-organized disposal of placentas in Dar es Salaam meant Zaramo women avoided maternity births in this city.¹⁴²

African American midwives of the South relied heavily on prayer during all phases of the birth experience. Midwives such as Aunt Belle, relied on prayer as well as a good relationship with the physician who had trained her.

Over forty years I been a granny midwife and no mother ever died with me. But I don’t take the credit myself. I always had the Lord and one or the other Doc Powells to call on in trouble. Sometimes the Lord just said to me, ‘You better send for the doctor to help you out, Belle, I’m telling you tain’t safe not to.’ I always minded the Lord and the Doctors and I everly been all times purity and clean.¹⁴³

¹⁴¹ Mary Beck Moser, “Seri: From Conception through Pregnancy.” In M. A. Kay, *Anthropology of Human Birth*. P. 227. See also, Marcha Flint, “Lockmi: An Indian Midwife,” for an account of the burial of the placenta in Rajasthan, India. In Kay, p. 215.

¹⁴² Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization and Mobility in the Congo* (Durham: Duke University Press, 1999) p. 8.

¹⁴³ Campbell, 109.

Testimony such as the one from Aunt Belle, shows the conversational tone that many midwives have described having with a superior being. Aunt Belle went on to describe a time when she had become older and no longer felt she had the vitality for midwife work.

I says, "Lord, I'm old and tired. Give me my long rest and let me come up there to stay with John Luke and the baby." But the Lord He says, "You aint so old as you will be. I got work yet for you to do down there and I'll give you strength. Go long, now and do your job..."¹⁴⁴

Prayer and conversations with the spirit infused many aspects of midwife work. A group of midwives in rural Georgia prepared a list for their public health nurse of some of the rituals that were associated with the traditional practices. For the mother, to prevent or stop a hemorrhage, they listed: "Tie black strings around the waist, Use cobwebs to coagulate the blood, repeat Ezekial 16:3 and 16:6." For a retained placenta they had on their list: "Patient blow in a blue bottle, set patient over hot chicken feathers."¹⁴⁵

Other rituals associated with the placenta were part of the mother's transition from childbirth to the postpartum period. Another important postpartum ritual was the mother's reentry into everyday life. It marked the end of her labor, and the successful delivery of her baby. The ritual usually involved the midwife escorting the mother and baby outdoors for the first time after the birth. "On the first day they were permitted out of bed, they carried the baby outdoors, walked around the house in a counterclockwise direction, and stopped at four corners which was said to symbolize the four corners of the wind."¹⁴⁶ Another midwife stated that this ritual was used to thank God for a safe delivery, and another explained it as a way to acclimate the woman to the outside air and to "close her pores so that she and the baby would not catch a cold."¹⁴⁷ Other

¹⁴⁴ Ibid, 109-110.

¹⁴⁵ Ibid., 35.

¹⁴⁶ Dougherty, "Southern Lay Midwives as Ritual Specialists," 155.

¹⁴⁷ Dougherty, "Southern Lay Midwives as Ritual Specialists," 155.

accounts describe the mother carrying a thimbleful of water around the perimeter of her home and then drinking it. The ritual usually involved all the members of the family and may have also been a way to incorporate a new baby into the family.

Claudine Curry Smith describes the practice of a new mothers staying in her home for several weeks after giving birth.

When I had all my babies you stayed in for a month and a lot of mothers I delivered in the 1950's did that. I made Shirley do that, too. But later on, if they stayed in three weeks they'd do good. Sometimes five or six days they'd be in town shopping. But you know, you can tell 'em, an they'll sit there and tell you that's old timey but people died in old time, and they still dying. They usually supposed to go for a check up after six weeks and the baby too.¹⁴⁸

The experience of childbirth had removed the woman for a period of time from the day-to-day activities of her family. Asking a woman to stay away from routines of everyday life for a period after childbirth was a way of acknowledging that she had been on a journey and had now returned. A re-entry ritual, such as those described, was the official go ahead for the mother to get back to her normal life, similar to the now routine six week visit to the doctor or midwife.

Not all rituals were so serious in nature, however. Another important aspect of the midwife's work and the experience of birth itself was to make the mother feel pampered and physically comforted during labor. One midwife recounted that unless impossible due to a medical emergency, she would never deliver a woman "with her hair flying." During the early stages of labor, the midwife would apply pomade and conditioners to her patient's hair and braid it. She also bathed her with fragrant soaps and massaged oils into her skin, especially on her legs. She applied talcum powder under her arms and sprinkled her with rose water or other scented

¹⁴⁸ Smith and Roberson, 85.

liquids.¹⁴⁹ This practice was enjoyable for the mother as well as her attendant. Yet it did prepare her well for the tougher stages of delivery that lay ahead of her. If her body was relaxed, she was more likely to be able to handle the harder stages of labor. This concept is widely accepted within the contemporary natural childbirth movement.

Herbal remedies and folk rituals comprised a primary set of techniques employed by African-American midwives of the South. The list of supplies used in folk remedies was extensive. A survey conducted by the U.S. Department of Health in several counties of North Carolina in 1918 highlighted many of the common articles found in a midwife's supply bag. The report stated that items found among midwives included, "ball thread, tansy, ergot, and half dozen triturated tablets given one midwife by a doctor." Most midwives administered "copious drafts of tea from time to time, made of pepper, catnip, sweet fennel, mint wormwood, or tansy."¹⁵⁰ Midwives in one county advised giving a tea of "cidyus elder" to reduce the swelling of hands and feet. Others gave single tansy tea for threatened miscarriage.¹⁵¹ A report from Louisiana regarding the methods employed by midwives there describes the use of "green pecan and persimmon tea to stop the 'hemmage' after the baby was born."¹⁵² Madame Colossi, a midwife and secret doctor from Louisiana used, "basil and mint tea faithfully." Her daughters told recounted that, "Mamma always kept this (basil), and we kept it up for childrens that come here, and that mint good for womens who just had a baby with a lotta cramps."¹⁵³ Madame Colossi used herbs for other ailments as well. Two of the midwives in the North Carolina study washed

¹⁴⁹ Mongeau, "The 'Granny' Midwives," 85.

¹⁵⁰ U.S. Department of Labor, "Rural Children in Selected Counties of North Carolina," 1918 (National Archives of the United States, College Park, MD [hereinafter NA]).

¹⁵¹ Ibid.

¹⁵² Deola Lange, "The Midwife at Present: Louisiana Midwives," 1948 (University of Alabama Archives, University of Alabama at Birmingham, Birmingham, AL, Series/Collection MC53 [hereinafter UAA], Folder 54.62), 10.

¹⁵³ Fontenot, 62.

the newborn's eyes with boric acid, catnip was used by three, catnip and camphor by one, plain water by two others and mother's milk by another. The report noted that none of the midwives interviewed had access to silver nitrate, the standard eye wash used by physicians. In absence of silver nitrate, the midwives relied on traditional methods for washing a newborn's eyes.

Herbal remedies are frequently used by traditional birth attendants in many parts of the world. Herbs are used in parts of Africa in cases of prolonged labor and herbal teas are administered in parts of Latin America. Zulu midwives in South Africa use a liquid which they make by soaking roots and herbs in hot water. In Guatemala herb teas are often mixed with liquor. In Jamaica spiced teas made of thyme are common. In Mexico teas are made with cinnamon, basil, and chocolate. Teas are often thought to give energy to the laboring woman.¹⁵⁴

Traditional birth attendants of the South used folk remedies to hasten labor as well as ease the pain of childbirth. A common ritual used to promote the stages of labor was for the midwife to throw hot coals from the fireplace on hen feathers and then place the ashes under the bed of the woman in labor. Or the feathers were burned in a pot and the laboring woman was asked to squat over them. These types of rituals along with drinking tea and reading the Bible were the most commonly used set of procedures.¹⁵⁵

Another account discusses the use of ties or cords in the prevention of miscarriage. In discussing the practices of her mother, a secret doctor, a woman from Louisiana stated that, "another thing she would use string for well like a lady would miscarriage or threaten, you would keep the string until about a month before you suppose to have the baby. Depends on what it

¹⁵⁴ Lefeber and Voorhoeve, 31-32. The use of teas are also mentioned in accounts from Rajasthan, India, and among the Seri Indians of Mexico, and among Mayan midwives in Guatemala. Flint, 214, Moser, 226. Cosminsky, 238.

¹⁵⁵ Litoff, *American Midwives*.

was for, the miscarriage it was a red thread.”¹⁵⁶ String was used in her practice for other female conditions as well. “You know womens they go three and four months without stopping from a period or something, well she would use a string and you would keep it on for nine days, or so many days until you lose the string.”¹⁵⁷

The power of traditional practices lay in their ability to provide comfort and a feeling of assurance to the mother. One of the most powerful tools the midwife employed was her ability to listen to and respond to her patient’s worries and fears. She often responded with rituals and traditional methods of healing. On other occasions one may go into the home during a delivery and find the midwife has placed the husband’s hat on the patient’s head and his pants under the pillow so that he can help the patient bear the pain. Placing an ax, knife, or other blunt instrument under the patient’s head to “cut” the pains was a popular belief as well among traditional midwives.¹⁵⁸

The midwife or her assistant employed common materials in such a manner as to transform them into medical supplies. The umbilical cord of the baby was tied in the traditional manner with cotton twine. One midwife interviewed claimed to use the ravelings from a flower sack while another used silk.¹⁵⁹ Materials likely to be found in the home of an expectant mother were transformed in this way into materials necessary for a birth. Other common household items such as newspaper and cloth towels were also used. On some occasions, however, households would not have the proper supplies handy and midwives had to improvise or supply their own materials. Midwife Claude Curry Smith states in her account that her bag was “always packed.”

¹⁵⁶ Fontenot, 63.

¹⁵⁷ Ibid.

¹⁵⁸ Lange, “The Midwife at Present.”

¹⁵⁹ U.S. Department of Health, “Rural Children in Selected Counties of North Carolina.”

She carried with her many of the supplies that were needed, including the more common household items.

My bag was always packed...I always tell all my patients before I came what I wanted, and I always told them to have the hot water on and the basin, and have the pads and plenty of newspaper to prepare the bed, and pans so I could wash the mother. But I always had my own sterilized towels and everything in my bag after each use.¹⁶⁰

She also describes some instances when the families did not have the proper supplies.

I discovered houses didn't have the proper stuff, and I got in the habit of bringing things in the car. I had several cases where they just didn't get things together, and I've been there when they didn't have anything. They had sheets on the bed, but they weren't clean. And they wouldn't have any newspapers. But I would say they just couldn't do any better.¹⁶¹

Midwives such as Claudine Smith were good at improvising with materials. There were a few cases when she made a gown for the mother with a sheet and scissors.¹⁶² She was able to do a lot with just a few simple items.

Another midwife by the name of Martha who practiced in rural Georgia described a similar incident. Despite her instructions to the family, when she arrived for the birth, there were no preparations or proper supplies for the mother and baby.

When I got there, not one clean thing about the place. I had to wash my hands in a battered old lard bucket – not no wash pan. No nothing. No wood even. I had to chop some wood before I could heat water to wash my hands...No sheet on the bed, The woman said she took the sheets off and never got them washed. I knowed she never had none. Her house and her family was always like that, sick or well. I had to put on her bed the big white sheet I carry in my bag to make a clean cover for work space. I had to spread out my white bag lining to work on.¹⁶³

¹⁶⁰ Smith and Roberson, 54.

¹⁶¹ Ibid., 55.

¹⁶² Smith and Roberson, 56.

¹⁶³ Campbell, 85-6.

These testimonies paint a picture of the conditions within which African American midwives often worked. The material resources of many families they served were meager. Yet, they had to find a way to serve the mother and baby the best way they could. With such limited resources, and difficult working conditions, it is no wonder they maintained such a strong alliance to their religious beliefs.

Among Southern rural communities at this time there was no contradiction in worshipping Jesus, reading the Bible, and believing in the healing power of herbs and other folk rituals. Midwives believed that the healing power of their teas came from God. Christianity and folk religious practices were coexisting, and even syncretized factors of the midwife tradition. Prayer was a primary aspect of healing work. In recounting the work of Madame Colossi, her daughter stated that, “The Indian lady taught her the prayers for treating...She always did say her prayers in French to herself.”¹⁶⁴ She describes the central role that prayer had in her practice. “Prayers is the most important thing, more than anything else, prayers can do anything. She would always say a prayer.”¹⁶⁵

Prayer was, for example, a regular occurrence before, during, and after a birth. It was meant to ensure a safe and successful delivery. It was believed that prayer had the potential to reduce the pain and suffering of the mother. Midwives prayed in order to receive guidance during a medical emergency, and to give thanks for a successful delivery. Mrs. Louvenie Taylor Benjamin, an Alabama midwife who began her work delivering babies in the 1920's, described the importance of prayer in her practice.

¹⁶⁴ Fontenot, 62.

¹⁶⁵ Ibid.

Oh Lord, I always prayed. Oh, yes ma'am, I always prayed. I'd get on my knees and tell the Lord what to do to help me. Anytime I'd have a case, I would always tell the Lord before I went and then I'd thank Him afterwards, after I delivered. Sometimes I'd do it right there, get on my knees and pray.¹⁶⁶

Mrs. Benjamin describes a particularly difficult case, the delivery of triplets, when she relied on prayer as her guide. She "spoke to the Lord" more during this particular delivery than in other normal cases. "I think the Lord got tired of me that night because I was nervous about those three. I just says, Lord, now you come here because I can't do this by myself. I would talk to Him like I was talking to another man."¹⁶⁷

Claudine Smith described her procedure during a situation when the baby does not begin to cry immediately after the birth. She relied on a technique passed down by her ancestors as well as prayer in this circumstance.

Once the baby was born, if it wasn't wreathing or crying, you gotta slap it on the buttocks, And then if they still didn't cry, I'd get two pails of water, one lukewarm and one cold, and I'd dip the baby in one, then the other about four or five times. I heard that from my one grandmother and a great aunt who was midwives. So I thought it was old timey, I was gonna try – and it worked. And too, you kinda start saying a silent prayer to God.¹⁶⁸

Midwives such as Ms. Benjamin and Ms. Smith communicated directly with a Christian God. They relied in what they believed to be the healing power of prayer during these challenging circumstances. This demonstrates the critical role that prayer played in the birth experience for these women and many others throughout the South at this time. It was almost as instrumental as

¹⁶⁶ Holmes, "African American Midwives of the South," 277-78.

¹⁶⁷ *Ibid.*, 278.

¹⁶⁸ Smith and Roberson, 85.

the supplies she carried in her bag. It seems that many midwives relied on prayer as much as on the limited medical procedures they had learned from various teachers.

African-American midwives frequently gave the credit to God for successful outcomes of birth. As Linda Janet Holmes has written, this was especially true for difficult or complicated cases.

In several instances when a midwife encountered a complication for the first time, she found strength through prayer.... [M]any of the midwives considered their ability to make rapid and appropriate judgments as much a spiritual experience as it was a synthesis of past technical knowledge.... [C]omplications that required the inner confidence of prayer included delivering triplets, managing breech presentations, and delivering a retained placenta.¹⁶⁹

As demonstrated in this quote, midwives often felt closest to God during the active labor of a patient. This was the most precarious time of their duties to a woman, and when they were most in tune with the communication of the spirit world and with God. As stated, when the outcome was positive for the mother and baby, the thanks went to God. Midwives did not typically take credit for successful outcomes, nor did they take responsibility for failures. Every outcome was due to the will of God. They did everything in their power to ensure a positive outcome, but not everything was in their power. They believed that their skills and their actions were directed by God, there was nothing in their work that did not come from Him. Thus, He deserved the credit for any type of outcome.

In summary, midwives such as Mrs. Louvenia Taylor Benjamin had extensive experience in childbirth. However, they attributed their success to their relationship with God, and this relationship was maintained through prayer. Claudine Smith describes prayer as the aspect of her work as a midwife that gave her joy and made her feel at ease before going to a birth.

¹⁶⁹ Ibid., 276.

The thing I enjoyed the most was when I left home to go, praying and hoping that everything would come out all right, and I just prayed that the Lord would help me and the baby and the mother. And most of the time, everything came out all right in my thirty-one years...

It was more joy that when I went there and with the Lord being over all of us three, the mother, the baby and myself, that when the baby came out and cried, and that baby was normal.¹⁷⁰

African-American midwives understood that a woman needed to feel safe during difficult moments of a delivery. They used prayer and communication with God to help women feel comforted. One midwife stated that when her patients began to struggle and become uneasy from the pain, she would tell them to “trust God.” She would tell them, “The Lord will put no more on you than you can bear. He know that you can bear this baby, trust Him and then everything will be all right.” She also stated that she would “talk with the Lord first, before I ever do anything.”¹⁷¹ In this example, prayer has a medical function, as it was central to the pain management techniques employed by midwives who had no access to medical forms of pain management for their black clients. By telling her patient that the Lord will not give her anything greater than what she can bear, she was in essence telling her to trust in a higher power and giving her confidence in her ability to manage the pain. The midwife was also tying the experience of childbirth to a larger religious belief system that had most likely carried her patient through other troubling experiences in her life. It reminded her to rely on the familiar experience of prayer and turning to God. Prayer and ritualistic techniques had a great deal of relevance for the African-American population of the rural South. Midwives effectively linked these techniques to the experience of childbirth and were often successful in encouraging the women to relax and trust in her ability to manage the situation no matter what the outcome was. This

¹⁷⁰ Smith and Roberson, 122.

¹⁷¹ Dougherty, “Southern Lay Midwives as Ritual Specialists,” 155.

technique also gave the woman a point of focus outside the physical experience of pain. This technique is similar to those used in the modern natural childbirth movement.

For African-American midwives of the South, the Bible was as important in their practice as the equipment they carried in their midwife bags. In order to mentally and spiritually prepare themselves for a birth, midwives prayed and read from the Bible. A midwife whose husband was a deacon in their church describes her use of prayer in the following passage.

I asked God to give me His guidance and not let anything come that I couldn't handle. I always want Him to be there. And, If I kind of feel myself a little down, I always go to my husband and when he prays I just get things over with. And, I have my Bible. I take my Bible with me and I always read it.¹⁷²

Certain passages of the Bible were read and interpreted during difficult moments of a birth. A medical emergency (i.e., when the life of the mother or baby was thought to be in danger) was a time when the Bible was consulted for support and reassurance. One Southern midwife recounted that when she was attending a woman who was at risk of hemorrhaging, she would elevate the woman's feet and read the Bible. In particular, Ezekiel 16:6 was referred to in cases of hemorrhage.¹⁷³ In this chapter, the Lord tells Ezekiel a story to describe how He saved the baby Ezekiel. The Lord tells him that on the day that he was born, he was left to die in a field: "[Y]our umbilical cord was left uncut, and you were never washed, rubbed with salt, and dressed in warm clothing.... [O]n the day you were born, you were dumped in a field and left to die,

¹⁷² Holmes, "African American Midwives of the South," 278.

¹⁷³ Dougherty, "Southern Lay Midwives as Ritual Specialists," 155.

unwanted.”¹⁷⁴ The Lord brought the baby back to life. “I helped you thrive like a plant in the field. You grew up and became a beautiful jewel.”¹⁷⁵

A telling account on the importance of the Bible in healing comes from a woman whose husband was a secret doctor in Louisiana. While she herself did not practice, she was the descendent of practitioners and spoke in place of her husband during an interview with ethnologist Wonda Fontenot. She stated that, “My grandfathers died at the age of ninety-one, and they believed in herbs and miracles. She was very clear about the importance of the Bible in healing work.

You mixing faith healing with secret healing. You find this in Corinthians 12, gifts of the spirit. The nine knots is for the nine moons and nine months it take to make the baby born. The string is for the navel string, the line is the tree and the children is the branches. Now you have seven months for the seven angels, the books of Ezekial, Verse 16, for the stopping of the blood...A life of prayer must be lived.¹⁷⁶

This testimony from Mrs. Jacque mentions the same passage, Ezekial 16, that was used by the midwife in the preceding example in the case of a woman suffering from excessive bleeding after or during a birth. That it is mentioned here to describe the work of a secret doctor indicates an overlapping and perhaps overarching belief system that enveloped practitioners of folk healing across multiple southern states. It certainly indicates that for many, who practiced, the Bible and certain passages in particular were central to their belief system and approach to healing.

During the 1920’s through the 1950’s, when lay midwives were organized by the state into midwife clubs, the Bible was read at their meetings in order to set the tone for a discussion of

¹⁷⁴ Ezekiel, 16:5.

¹⁷⁵ Ezekiel, 16:6.

¹⁷⁶ Fontenot, 60.

childbirth practices. A Mississippi midwife club leader from Carroll County reported that her meeting was opened by singing the midwife song and reading a chapter of Mark. After this the usual business of the midwife club was conducted.¹⁷⁷ Although the context of this reading is not the birthing room, it reflects a similar theme of healing. The chapter describes Jesus as a healer of the sick. In one story, he heals a woman who has had a hemorrhage for twelve years and has been seen by many doctors.¹⁷⁸

The risk of hemorrhage from childbirth was a constant in the practices of African-American midwives. Many of their ritual, herbal, and spiritual healing methods were intended to prevent or stop the mother's bleeding. They read passages from the Bible that referred specifically to the healing of the abandoned, the sick, and the bleeding. Midwives believed that they assisted and guided a woman during a birth, but that the actual healing work was performed by God. The Bible was always present in their work and they were confident in their ability to summon the healing powers of spirit.

Managing the physical pain of childbirth was, for African-American midwives with very limited access to anesthesia, an area where traditional methods of pain management were relied upon. It was common for a midwife to use herbal teas to help women manage labor pains. Lavine McKee, a midwife in South Carolina who practiced during the 1930s, recounted that in the case of a painful labor she would give the mother a tea made from a dirt dauber's nest.¹⁷⁹ Midwife, Claudine Curry Smith used a very simple set of practices for pain management. The primary goal was to comfort the mother. She also relied on teas.

¹⁷⁷ Mississippi Board of Health, "The Relation of the Midwife to the State Board of Health," January 1, 1935 (Mississippi Department of Archives and History [hereinafter MDAH], Record Group [hereinafter RG] 51, Location [hereinafter Loc] 11-18-1, Box 8416).

¹⁷⁸ Mark, 5:25–26.

¹⁷⁹ Edward Beardsley, *A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South* (Knoxville: University of Tennessee Press, 1987), 39.

I'd get to the house and first thing I'd do was pull off my jacket if it was cold weather. Then I'd go talk to the mother to see what's what. Then I'd wash my hands with the soap and hot water like you supposed to and I'd prepare the bed with the padding and all for protection. And I'd sponge her off and look at the perineum to see if she was dilating... Then I'd wash my hands again. If the pains were so many minutes apart, I'd let her walk. The only thing I'd give her was a cup of tea. And I'd talk and joke with her, to help her relax.¹⁸⁰

Midwives across the South utilized techniques and rituals that they had learned from their forebears for pain management as well. Midwife, McKee, recounted that if the dirt dauber tea was unavailable, "pains could be 'cut' by placing a sharp tool like a knife or hoe under the patient's bed or by rubbing her body with sulfur and lard.¹⁸¹ Midwife, Margaret Smith, used a similar version of this ritual in her practice.

The midwife would slip a knife, sharp fork, or scissors under the bed, between the mattress, but you didn't have to let the person know it was there. You had to put it in there the day after, when they were asleep. Open the scissors and point them down or point them up. That helps ease the pain... just stick those scissors under there and let them be open, and it helps a whole lot. It soothes those pains down.¹⁸²

Other common rituals included placing a pair of the husband's shoes turned upside down under the patient's bed to help her "carry" the pain and throwing hot coals on hen feathers and putting the ashes under the bed.¹⁸³ This set of practices is consistently referred to within southern testimonies. The majority of midwives who have been interviewed by scholars used one or a combination of these techniques. There is a power in their consistency. They were handed down by predecessors, and had strong ties to the overall culture of healing and faith which was predominant in rural areas of the South.

¹⁸⁰ Smith and Roberson, 64.

¹⁸¹ *Ibid.*, 39.

¹⁸² Smith and Holmes, 98-9.

¹⁸³ *Ibid.*; Litoff, *American Midwives*, 31.

The role of the midwife continued well after the birth had occurred. For several days after a birth, the mother and baby were still considered to be in a precarious state and thus still needed the midwife's guidance and ritualistic support. Several common postpartum rituals were employed to assist the mother and baby in their reintegration to society. Some midwives and mothers believed that during the postpartum period no fire should be removed from the house of the mother and that it should not be swept. Midwife Margaret Charles Smith was very specific about this in her testimony. "We used to say, if the baby's born at home, you got to keep the fire burning one night, twelve hours, then it can go out. You couldn't take a fire out of the fireplace where the mother was for four or five days."¹⁸⁴ In interviews, other midwives from Alabama spoke about their belief that there should be no sweeping under the bed of a mother in the postpartum period and that no ashes should be removed from the fireplace during this time.¹⁸⁵

Many of the remedies and practices described were considered superstitious by the medical community. Before midwives were regulated and supervised by public health nurses in the 1920s, they used them without controversy. White male physicians who apprenticed black women midwives before 1920 were aware of their reliance on ritual and use of herbal remedies during birth. They did not attempt to dissuade them from practicing folk medicine. According to nurse Jessie Marriner, director of Child Hygiene and Public Health Nursing for the Alabama State Board of Health, the physicians "condoned when they did not actually encourage the superstitious practices of the midwife with whom they came into contact."¹⁸⁶

Beatrice Bell Mongeau, an ethnographer who collected stories from midwives of North Carolina in the early 1970s, describes a working relationship between physician and midwife that

¹⁸⁴ Smith and Holmes, 98.

¹⁸⁵ Linda J. Holmes, "Medical History: Alabama Granny Midwife," *Journal of the Medical Society of New Jersey* 81, no. 5 (1984), 390.

¹⁸⁶ Jessie Marriner, "Midwifery in Alabama," *Public Health Nurse* 18, no. 3 (March 1926), 128.

was based on mutual reliance. The physicians needed the midwives to cover cases they could not attend due to the codes of racial segregation. In return, midwives relied on the physician for medical training, access to new methods of healing, and medical supplies. The physicians of North Carolina appeared to have condoned the alternative practices of midwives because they did not interfere with their own practice or authority. One of the doctors interviewed by Mongeau claimed that the midwife he worked with “was very superstitious, and mystical and that she practices magic.”¹⁸⁷ The doctor did not know exactly what rituals the midwife performed, and he did not need to know. It is likely, given the testimonies of other midwives, that she would have saved her ritualized techniques for her African-American clients who were for the most part not also being seen by the physician.

By the early twentieth century, the practice of traditional folk medicine had become directly linked to the maternal and infant death rates of the South by the medical establishment. African-American midwives who were the bearers of this tradition became targets of mainstream medical professionals, and in most cases it was their practice of “superstition,” “magic,” or “voodoo” that was considered to be the most dangerous to mother and infant. According to Holly Mathews, who has researched the practices of African-American midwives, they were “blamed for the failure of women and of the general public to adopt modern standards of medical care for delivery.... Women suffering the complications of labor would assume everything was normal if the ‘old black mammy’ said that it was.”¹⁸⁸ Given the history of African-American midwifery and its deep ties in the Southern black community, it is easy to understand why this may have been the case. There was a deep trust in the midwife, and her traditional practices.

¹⁸⁷ Mongeau, “The ‘Granny’ Midwives,” 61.

¹⁸⁸ Mathews, “Killing the Medical Self-Help Tradition,” 63.

To some, the appeal of the midwife may have had to do with her commitment to the geography of the rural south. Catherine, a midwife interviewed in the early 1970s, stated that neither she nor her mother or grandmother had ever lived out of the sight of a certain great oak tree that could be seen from the front door of her home. Catherine's statement reveals a commitment to place. Generations of women in her family were a visible and reliable presence in their community. During a time when many thousands of people migrated from the South, African-American midwives remained in some cases in almost the same location where they had been born. They were firmly established in their communities, and therefore hardly felt the competition from an outsider such as a nurse or new doctor.

A midwife assisted home birth was part of the normal way of life during the time period discussed. This contributed to a sense of security women entrusted to their midwives. For African American women of the south, a midwife assisted home birth was accepted as the natural and undisputed choice from the time of enslavement through the first half of the twentieth century. Having a physician in attendance was for some not generally considered to be preferable to the midwife. One Texas woman claimed that she was "used to women and not strange men like doctors." Another woman stated that she never knew anything else but midwives and that they were "just handed down from slavery times."¹⁸⁹ An account from a black doctor in rural Virginia also indicates that home births were the norm for rural women.

I was born at home in 1918 and home deliveries were the norm. But when I went through medical school in the early 40s, the teaching was that home delivery was a bad thing and everybody should be brought in the hospital for 10 to 14 days. And I come down here in 1947 and found out very quickly that wasn't necessary. Until the mid-1950's when a couple of local doctors added maternity wings to their offices, most women, both Black and White, delivered at home. The majority of Black women used midwives, unless there were problems anticipated through prenatal visits to the doctor.¹⁹⁰

¹⁸⁹ Ibid.

¹⁹⁰ Smith and Roberson, 24.

This account, which is from the perspective of a male physician, highlights that the teachings of medical institutions were not in accord with the beliefs of the rural populations of the South. Childbearing women and their families, for the most part, accepted and welcomed the presence of the midwife.

Linda Janet Holmes, who has researched the lives of African American midwives, stated that “under Jim Crow laws the need for indigenous healers became more pronounced as black Americans were barred from mainstream medical services. Most white hospitals were segregated. Blacks had a distrust of medical care, even black hospitals.”¹⁹¹ African-American childbearing women did have a deep distrust of the medical world. This distrust stemmed as much from what was in the medical world—“strange men like doctors”—as from what was not in it—a deep connection to their religious belief system.

African-American midwives of the South did not share the fears of the women they attended in the first several decades of the twentieth century. They considered themselves to be part of the medical community. They saw themselves as translators of modern medicine. At this time, medical professionals were not a threat to their practice and did not encroach upon their authority among the women they served. They were a source of new information that allowed them to enrich their practices with bits and pieces of the modern world. While they were portrayed at this time by national medical authorities as backward, they were actually forward thinking and adaptable.

As much as they were willing to incorporate new techniques into their practices they were equally as unwilling to replace traditional ones. As long as the medical community did not ask,

¹⁹¹ Smith and Holmes, *Listen to Me Good*, 35.

or expect them to replace such traditions, they enjoyed a mutually beneficial relationship to the medical professionals they worked with. They relied on their intuition to guide them through decisions about the best formula of modern and traditional practices to administer to their patients. Their practices evolved slowly but steadily alongside those of the local physicians of the South. As stated by Molly Dougherty, “Medical concepts, such as aseptic techniques, were combined in midwifery with traditional rituals that were embedded in the Christianity practices by the midwives and their clients.”¹⁹² African-American midwives did not see either practice as interfering with the effectiveness of the other. This made them truly unique health workers for the time. Traditional rituals were given their effectiveness, according to midwives and mothers, by their association with religion. Religion and spirituality was the central characteristic of midwife work and the experience of childbirth in the early twentieth century for the African-American population of the South, which accounted for the majority of the black population in the United States. The women of this community were attended almost exclusively by the midwives of their community with whom they shared an intuitive and personal understanding of God.

The midwife quoted in the opening of this chapter stated that the “good Lord taught me how to catch babies.” She stated that she “worked with doctors,” and that she “used herbs.” These statements encapsulate some of the primary characteristics of midwife work in the first few decades of the twentieth century, before the onset of state-run training and regulation programs. Midwives believed that they received all of the most important information about how to care for mothers through direct communication with a Christian God. This was how they often described their training. But in reality, their practices and process of receiving information was far more

¹⁹² Dougherty, “Southern Lay Midwives as Ritual Specialists,” 152.

diverse and varied. They learned certain techniques and received supplies from doctors they worked with, and they also used herbs and performed rituals they had learned from generations of practicing midwives. A midwife by the name of Elizabeth, who earlier was described as never living outside the view of a certain oak tree in her front yard, described the varied nature of midwife work in this time period:

Midwifery is what she practiced when her clients engaged her to deliver them. "Following the doctor" was assisting him in the home of his white clients (she never "followed the doctor" in the home of a nonwhite client, it was he who assisted her). Being a midwife and following the doctor were basic skills she learned from her grandmother. Midwifery, following the doctor, and doctoring were, to her, three different disciplines. She already knew two of them, so the new skills she learned from the physician and the objects similar to his she added to her bag were considered doctor's ways. She was a midwife, but when she gave ergot, wore an apron like the doctors and used his scissors, she was 'doctoring.'¹⁹³

Midwives such as Elizabeth worked in the homes of white as well as black women. Their practices were different in each. In white women's homes, she was described as playing the roles of "nurse, maid, mother, organizer, and comforter for the patient until the doctor came to take over."¹⁹⁴ Very often, however, the doctor never did come to take over, and so she delivered the baby as well. The doctor was always "expected at any moment," and so the charade went that the midwife was performing an exceptional duty. Yet it seems clear that during this time period there was a deep trust between local physician and traditional midwife. He worked with her and taught her enough of his own skills to trust her with his white clients. The white women also seemed to have trusted her as well and there is no evidence that her presence at the birth was questioned. It was understood that she was filling in for the doctor and that she was using her "doctoring" skills.

¹⁹³ Mongeau, "The 'Granny' Midwives," 61.

¹⁹⁴ Ibid.

When the traditional midwife was with her black clients, she was practicing “midwifery” in the traditional sense, “the secrets of which she divulged neither to the doctor nor his white clients.”¹⁹⁵ The rituals associated with “midwife” work would not have been effective on white Southern women because of cultural differences in terms of childbirth practices. This is where the system of racial segregation had an impact on the medical experiences of the two groups of Southern women. Despite the close physical proximity of the two races, there was a deep divide in terms of approaches to medicine. African-American women had a deeper sense of distrust of modern medicine, and held the spiritual nature of healing work very close to their sense of well-being.¹⁹⁶ White women trusted midwives because they performed like doctors when they were with them, and black women trusted midwives because they did *not* perform like doctors when they were with them.

The spiritual nature of midwife work was the central defining characteristic of the experience of childbirth among Southern African-American women. Medical validity and spiritual validity were not competing, but rather complementary, forces in the experience of childbirth for this group of women. The traditional healing practices of midwives that were religious in nature had a medical validity as well as a spiritual validity for black midwives and mothers of the South. They were as confident in the power of reading certain passages of the Bible to heal women in labor as they were in administering medicines obtained from the local physician.

Their traditional practices existed behind the racial veil, within the racially segregated black community, and were not a threat to the medical system of the time. Therefore, they were left alone to continue their practices undisturbed by the outside world. This came to an end after the

¹⁹⁵ Ibid.

¹⁹⁶ The distrust that many African American women held was the result of mistreatment by medical professionals and institutions. This topic will be discussed further in a later chapter of the dissertation.

1920s, when suddenly infant mortality rates became a prominent issue for national health-care institutions. New health-care workers often did not take into account the cultural relevance of spiritual midwife work, and therefore were not effective in their attempts to turn midwives and mothers against it.

Chapter Three: The Surveillance of Birth

In 1921, Laurie Jean Reid, a U.S. Public Health Service nurse, made a presentation to the Mississippi State Medical Association of her proposed plan for the supervision of midwives. Reid found it troubling that the state required its 1,700 practicing physicians to meet certain medical qualifications to practice, yet the estimated 3,000 to 4,000 active midwives in Mississippi were practicing independently and according to their own standards.¹⁹⁷ These women were, according to Reid, “illiterate, ignorant, negro women, without the knowledge of the first principles of ordinary soap and water cleanliness, and who are daily attending at the birth of some precious baby.”¹⁹⁸ This statement set the tone for midwife regulation work in Mississippi. The focus was on the unclean and “backward” practices of midwives and the fragile nature of newborns and mothers.

Reid asked her audience of medical professionals to visualize “the uneducated negro midwife, who goes to the average poor family with her lack of knowledge, but multiplicity of superstitions, her insistence on a clean bed, but her equal determination to have as she terms it ‘all de mess on de flo’.”¹⁹⁹ This description of the traditional midwife was intended to arouse the racial and class biases of the physicians present. The social anxiety generated by Reid was the foundation for the establishment of the first comprehensive plan for midwife regulation in the South.

¹⁹⁷ Laurie Jean Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” *Transactions of Mississippi State Medical Association* (1921), 176 (MDAH, RG 51, Loc 12-22-4, Box 8573).

¹⁹⁸ *Ibid.*, 177.

¹⁹⁹ *Ibid.*

Women across class and racial lines had a very real fear of death relating to childbirth in the early decades of the twentieth century. Prior to the 1900's the opinion of most Americans was that childbirth was a natural process, and that the home was the safest place for a child to be born. Hospitals were perceived as a dangerous place for a birth.²⁰⁰ In 1910 the United States had a recorded infant mortality rate that was the third highest in the world.²⁰¹ In 1915 approximately 10 percent of all infants died before they were one year old. The rate was twice as high, 20 percent, for infants of color.²⁰² Approximately six white women for every thousand live births died in childbirth between 1900 and 1930. For women of color the number was ten in a thousand for the same time period.²⁰³ According to a report from the American Child Health Association, the infant mortality rate for 515 cities across the United States was 77.9. In 1922, it was 79.6 in 583 cities. According to the report, six of the fifteen cities that had the highest infant mortality rates were in Southern states, attributed to higher numbers of African Americans in the South. "Rates for the white and colored populations of these cities for 1925 show that excess infant mortality rates prevail among the colored population, and these cities therefore take their place among those having the highest infant mortality rates because of the relatively large proportion of negroes."²⁰⁴ Several examples are provided of cities where the infant mortality rate for that city was higher among African Americans than for the whites of the same area. In Richmond, Virginia in 1925, the rate for the white population was 67.4, and for the black population, 131.7. In a study of rural areas, it seemed that infant mortality rates were lower for rural areas between 1915 and 1930, and declined overall in the United States. In 1915, there

²⁰⁰ Cathy Melvin Eford, "A Geography of Lay Midwifery in Appalachian North Carolina" (PhD diss., University of North Carolina, Chapel Hill, 1985), 40.

²⁰¹ Ibid.

²⁰² Ladd-Taylor, 18.

²⁰³ Ibid.

²⁰⁴ S.J. Crumline, "A Statistical Report of Infant Mortality for 1926," *American Journal of Public Health* 17, no. 9 (September 1927): 922-27.

were 99.6 recorded infant deaths per 1,000 live births, and in 1930, 62.1 per 1,000 live births.²⁰⁵ The report author states that a further reduction in infant deaths would occur if there were more general and adequate prenatal, natal, and postnatal care for mothers.²⁰⁶ A personal experience with birth related deaths led many women to organize for child welfare reform. This is what Ladd-Taylor has referred to as the “intersection of private life and public policy.”²⁰⁷

In 1912, the federal government established a Children’s Bureau. It was founded and run by a group of, “politically motivated” middle class women reformers.²⁰⁸ According to historian Theda Skocpol, “the Progressive Era was the time when the nationwide political mobilization of American middle-class women reached its height, when women agitated for maternalist social measures.”²⁰⁹ Julia Lathrop, the agency’s first chief, selected infant mortality and maternal mortality as the first issues to be addressed on a national scale.²¹⁰ It was an issue which touched women from all economic and social backgrounds, however the greatest impact was on working class and impoverished families. The Bureau compiled statistics on infant mortality and found that it was directly related to the low income of working-class fathers. Mothers of these families were often forced by necessity to work outside the home usually at low paying and physically draining jobs. These dual factors contributed to an infant mortality rate that was higher than those of other groups.²¹¹ Julia Lathrop and the Children’s Bureau had identified their first cause. “Studies by the Children’s Bureau had demonstrated a ‘close connection between infant

²⁰⁵ J.H. Mason Knox, “Reduction of Maternal and Infant Mortality in Rural Areas,” *American Journal of Public Health* 25 (January 1935): 68---75.

²⁰⁶ *Ibid.*, 69.

²⁰⁷ Ladd-Taylor, 2.

²⁰⁸ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), 317-9.

²⁰⁹ *Ibid.*, 319.

²¹⁰ *Ibid.*, 486.

²¹¹ *Ibid.*, 491.

mortality and the ill health and death of mothers.”²¹² In addition the Bureau investigations revealed that, “mothers and babies in America’s rural areas frequently suffered from lack of access to basic health information and obstetrical services.”²¹³ It became clear that the program had to encompass rural as well as urban areas and focus on distributing information and services to lower income families.

The final result of these findings was the passage of the Federal Act for the Promotion and Welfare and Hygiene of Maternity and Infancy, or the Sheppard-Towner Act as it was commonly called. The Children’s Bureau was given over one million dollars of annually for five years to distribute to states that agreed to cooperate with the program.²¹⁴ The funds were used to subsidize prenatal clinics, training and regulation of midwives, and the distribution of health information for mothers.

The dissemination of health information regarding pregnancy and infant health symbolized a shift in the relationship between motherhood and the federal government. As historian Molly Ladd-Taylor has made clear, “women have always sought advice and assistance with childrearing from female friends and family members, but their growing dependence on help from government and medical experts outside their own networks was new to the twentieth century.”²¹⁵ The motivating force behind this shift was the effort to reduce the mortality rates of infants and mothers.

Medical officials attempted to pinpoint the cause of elevated mortality rates among the non-white population of the South. The author of one study conducted in the early twentieth century pointed out that the elevated infant mortality rates among the Southern black population had to

²¹² Ibid., 495.

²¹³ Ibid., 495.

²¹⁴ Ibid., 481.

²¹⁵ Ladd-Taylor, 17.

do with lower “moral and sanitary standards.” Officials assumed a direct link between standards of morality and infant mortality rates. “In the South too, our mortality statistics are affected unfavorably by a large negro population in which the morbidity and mortality rates are nearly double those of the whites.”²¹⁶ These conditions were not considered to be inherent or irreversible, however. The author of the study provided an example of a county in Maryland where the infant mortality rate among the African-American population was lower than that of the white population. This was attributed to the presence of a black public health nurse who was working with the community.²¹⁷ Francis Kobrin wrote in a 1966 article that the midwives of the early twentieth century could be held responsible for deaths from “puerperal sepsis and for neonatal ophthalmic [conditions], both preventable with the knowledge available at the time.” However, it also had become clear that “general practitioners were at least as negligent as midwives, as well as being equally responsible for preventable deformities.”²¹⁸

For Reid, the “superstitious” practices and “abysmal ignorance” of the midwives of the South were pinpointed as the primary culprits for the elevated death rates.²¹⁹ The aspects of traditional midwife work most abhorrent to the reformist nurses of the time were based on folk religious and medical practices. The African American midwives of the South began to be referred to as problems, and the goal was to bring them under the control of the state run health department.

²¹⁶ Ibid., 73.

²¹⁷ Ibid.

²¹⁸ Francis E. Kobrin, “The American Midwife Controversy: A Crisis in Professionalization,” *Bulletin of the History of Medicine* 40 (1966), 351.

²¹⁹ See *ibid.*, 350–351, for a discussion of the medical community’s assault on midwives in the first decade of the twentieth century. Kobrin argues that midwives were found to be no more guilty than obstetricians of maternal or infant death from puerperal sepsis or neonatal ophthalmia. Midwives were blamed for elevated mortality rates in order to convince women that they should employ obstetricians. Reid’s depiction was an extension of the overall campaign to malign the midwife. See also Debra Ann Susie, *In the Way of Our Grandmothers: A Cultural View of Twentieth-Century Midwifery in Florida* (Athens: University of Georgia Press, 1988), 4. Susie argues that in addition to being competition for their business, midwives were blamed for the low status and economic rewards of obstetricians at the time.

Most health department officials sanctioned midwives but did not favorably view their role in the birth experiences of the South. “Steady progress is being made in eliminating the unfit midwives and in instructing those who practice. Even the better midwife, however, has definite limitations. She cannot examine her patient, give her prenatal care, or deliver her if she presents abnormal symptoms.”²²⁰

Nurse Reid considered it her moral obligation to “protect the public ... by setting standards of education and training, and maintaining close supervision over all women who handle obstetrical cases.” She concluded that the previous “policy of ignoring the midwife helps no one except the undertaker.”²²¹ Midwife regulation work was considered a moral obligation and the duty of those who were involved in maternal and child health organizations during the 1920s.

While medical professionals feared the practices of traditional midwives, they recognized they could not do entirely without their services. There were not enough doctors available to deliver the large numbers of African-American women in the South. As historian Jane pacht Brickman has stated, “Most public health leaders urged midwifery regulation, but only as a temporary measure. While attempts to elevate standards were sincere, health administrators rarely saw the midwife as more than a necessary – and most likely ephemeral – evil.”²²²

The following statement illuminates the difficulty medical professionals had in deciding the proper course of action that should be taken in regard to what they perceived as the midwife “problem.”

Existing legislation gives the midwife recognition but controls her ineffectually, if at all. The problem still to be solved is whether adequate provision shall be made for medical attendance at every confinement and the midwife abolished, or whether midwives shall be trained and

²²⁰ Knox, 72.

²²¹ Reid, “Plan of the Mississippi State Board of Health,” 176.

²²² Brickman, 71.

practice under strict supervision and control. Obviously, there is no point in eliminating even the untrained midwife without making qualified substitutes available.²²³

Professionals recognized that there was no substitute for midwife services at the time of the imposed regulation. The solution reached by Reid and others, was to reduce the numbers of practicing midwives to a number that they felt could be managed and trained by the available medical staff of each Southern state, and to force these women to abide by the medical standards and procedures of respective health departments.

A strict outline was prepared for midwife work in the state of Mississippi. Nurse Reid outlined a plan that was intended to resolve the problems she had identified with the current state of midwife work in Mississippi and throughout the South. The first step was to arrange a meeting of all the active midwives in each county.

By prearranged plan the midwives will be gotten together, their personal qualifications, the standard of their work in their community; with the local medical profession; and county health officer, investigated, and a “permit to practice” issued to those coming up to requirements.²²⁴

Midwives were interviewed to assess their “personal character and general intelligence,” “cleanliness of person, ... home and ... midwifery equipment.” Each midwife was investigated to determine whether she carried “instruments which a midwife is not permitted to use,” her “ability and willingness to apply preventive measures against Ophthalmia Neonatorum,” her “reputation for calling a physician in difficult or abnormal cases,” and her “record for reporting

²²³ Anna Rude, “The Midwife Problem in the United States,” *Journal of the American Medical Association* 81, no. 12 (1923), 987.

²²⁴ Reid, “Plan of the Mississippi State Board of Health,” 181.

births to the proper authorities.”²²⁵ The midwives who were given a health department permit to practice agreed to attend only cases of normal labor and to call a physician immediately if a problem should arise during the delivery. They were also required to agree to use prophylactic drops in the eyes of every newborn they delivered immediately following the birth, and to report the birth to the local registrar of the district in which the birth occurred within ten days. If a midwife did not follow these requirements, it was said that she could lose her license and be asked to discontinue her practice.²²⁶

The women considered “fit to practice” were given rudimentary training. They were given instructions in how to prepare a bedroom for delivery, how to clean their hands and instruments in preparation for the birth, and exactly what materials they should use for each stage of labor and delivery. Midwives in Mississippi were given a precise list of the materials they should have ready for a birth, including their midwife permit, blank birth certificates, and sterile supplies such as a nail brush, wooden nail cleaner, blunt scissors, cord dressings and a clinical thermometer.²²⁷ They were also instructed in what not to bring. Herbal teas were not permitted in the midwife bag. The focus was on eradicating any items associated with the traditional practices of midwives that were given power through their spiritual beliefs. These items were held to be the most threatening and to put the mother and baby at risk. In an article written by a nurse-midwife who worked with lay midwives in Arkansas in the 1940s, there is a description of what she considered the line between dangerous and benign traditional practices.

²²⁵ Mississippi Department of Health, “Midwife Supervision, Statewide Survey” (MDAH, RG 51, Loc 11-18-1, Box 8416).

²²⁶ Reid, “Plan of the Mississippi State Board of Health,” 181.

²²⁷ Mississippi Department of Health, “Midwife Supervision, Statewide Survey.”

Some of the superstitions of the midwife were harmless, but many of them risk the life or health of the mother or baby.... She may humor the midwife in such harmless ideas as putting an ax under the bed to cut the labor pains, putting the husband's trousers under the head of the bed so that he can "share them labor pains," biting the fingernails so that the baby "won't be a rogue," or putting salt on the afterbirth as it is being burned so that the mother "won't have no trouble." But she forbids such practices as giving red pepper tea to make the baby come faster, spitting in the baby's eyes to "keep them from getting sore," putting soot on the cord to make it "heal up well."²²⁸

An article that discusses midwife supervision work in Alabama also discusses the practices of midwives that were considered physically harmful to the newborn.

One marvels that any infant survives the well meaning colored midwife's routine during the interval between birth and the appearance of breast milk, when almost invariably a pacifier of raw white pork is given soon after birth for it's [*sic*] supposed laxative effect, supplemented at frequent intervals by curious and oft-times obnoxious concoctions known as "teas."²²⁹

As discussed in the previous chapter, teas were relied upon by the midwives of the South.

They were used as evidence that traditional practices were malicious, and that midwives could be dangerous if not regulated by state authorities. When not under strict regulation, the midwife was considered a threat to the health of Southern women and children. As one nurse in charge of midwife regulation work in Alabama stated, "at her worst the midwife is unteachable, unruly, and vicious and constitutes a serious menace to infant life and the lives of mothers."²³⁰

Professionals assumed that midwives were unable to handle a medical crisis without the intervention of a physician. Midwives were instructed to call a physician if a symptom of an abnormal delivery appeared. Any evidence of "hemorrhage, abnormal presentation, retained

²²⁸ Mamie O. Hale, R.N., "Arkansas Teaches Her Midwives," *The Child*, October 1946, p. 4.

²²⁹ Rude, "The Midwife Problem in the United States," 991.

²³⁰ Jessie Marriner, "Midwifery in Alabama," *Public Health Nurse* 18, no. 3 (March 1926).

placenta, convulsions, and prolapsed cord” warranted a call to the local physician.²³¹ The responsibility for securing the assistance of a physician was placed on the midwives, and many midwives did call a physician when they feared for the health of mother and baby, as they were instructed to do by the health department.²³² According to the nurse Anna Rude, who documented conditions in Alabama, midwives were doubly burdened in this state, as they were required to obtain additional training and yet were still proscribed from attempting to save the lives of women under their care without the help of a doctor. “Most of these regulations have been dictated by bitter experience, but with no specific effort to assist the midwife in her imposed responsibility of securing skilled assistance. Training and supervision have so far tended to diminish the numbers of practicing midwives.”²³³ There were fewer numbers of midwives and increased responsibility placed upon them for training and ability to secure the presence of a physician during an abnormal birth.

In her description of the midwife regulation program outlined for Mississippi in 1921, Nurse Reid made it clear that the plan was not meant to elevate the status of the traditional midwife, but to bring her practice under the control of the state and local board of health.

The State program has been essentially one of supervision and control by yearly, renewal of permits through countywide meetings and concentrated educational programs and has functioned as a cooperative one with county health departments since the beginning. Since existing conditions made this type of program necessary, it has not been a program of promotion but of supervision.²³⁴

²³¹ Rude, “The Midwife Problem in the United States,” 991.

²³² Mississippi Board of Health, “The Relation of the Midwife to the State Board of Health,” January 1, 1935 (MDAH, RG 51, Loc 11-18-1, Box 8416).

²³³ Rude, “The Midwife Problem in the United States,” 991.

²³⁴ Mississippi Department of Health, “Midwife Supervision: Statewide Survey,” p. 104 (Public Health Nursing, Correspondence, Memoranda, and Reports Documenting the History of Public Health Nursing [Principally Midwifery] in Mississippi, 1930–1950, MDAH, RG 51, Loc 11-18-1, Box 8416).

This plan for Mississippi was similar to those being developed in other Southern states. The focus was on supervision of the midwives who were active in each state. Midwives trained with state health officials in rudimentary birth procedures.

In some states, including Mississippi, African-American nurses were able to successfully connect with active midwives and offer instruction in a format that was accessible and easily absorbed into the existing practices of local midwives. Eliza Farish Pillars, R.N., was the first public health nurse in Mississippi. She was a graduate of Hubbard Hospital in 1912, and began working in Mississippi in 1926. The majority of her time was spent training midwives. Pillars held countywide meetings to renew midwives' permits and to provide special instruction.²³⁵

Six intermediate lessons were given to small groups of midwives, preferably in a home of one of the midwives. Lectures were given in very plain language, supplemented by lessons simply and carefully given step by step, first by the nurse and then by the midwives.²³⁶

Through the program headed by Pillars, the midwives brought some of their prenatal patients with them to midwife instructional meetings so that they would be exposed to further prenatal information and be checked by the nurse. When possible, Pillars obtained “influential and progressive” members of the community to speak to the midwives at meetings. She made visits to the homes of each active midwife and to the homes of some of their clients as well. Individual record cards were maintained on the activities of each midwife, where the history of her work was noted and her record of attendance at midwife meetings and inspections was kept.²³⁷ The underlying impetus of these measures was that of surveillance and control, yet some nurses such as Pillars were able to provide meaningful instruction as well. It is tempting to speculate that since Pillars allowed meetings to take place in the homes of the midwives, and since her teaching

²³⁵ Ibid., 105–106.

²³⁶ Ibid.

²³⁷ Ibid., 106.

style was described as being simple and direct, that she was able to tap into and effectively improve on the traditional styles of midwifery. Pillars was able to provide useful information to the midwives under her direction.

Other nurses working in the South were successful in their styles of teaching and instruction. African-American nurses working among midwives in Texas were “well trained in nursing schools and through their direct contact in the homes assist in improving standards of living, sanitation, and hygiene among the people of their race.”²³⁸ African-American nurses were working in a number of Southern states, including Alabama, Georgia, Maryland, Mississippi, and South Carolina. There is at least one account that describes the work of African-American nurses to be potentially more effective than that of others working among midwives.

Women were hired from Northern Institutions specifically for the job of midwife supervision. The nurses who sought to fill these posts were young colored nurses of pleasing personality. They were brought from the North and were trained by the state nurse to supervise, hold classes, and inspect the midwives’ bags.... It was thought that their color and youth would be more persuasive to the most resistant of the old midwives. The older women often resisted the regulation of the board of health and had the support and status from her community to back her in doing so.²³⁹

Iona Whipper was an African-American physician who worked among traditional midwives of the South. She also appeared to have more success using a direct and community-based approach. She was hired by the Children’s Bureau for the express purpose of “investigation and educational work among negro midwives.”²⁴⁰ Dr. Whipper initiated her work in a new community through tapping into preexisting social networks. “Whipper gained access to the midwife network through key people in the black community. In Tennessee Whipper found that

²³⁸ U.S. Department of Labor, *The Promotion of the Welfare and Hygiene of Maternity and Infancy*, Children’s Bureau Publication no. 194, June 30, 1927, p. 28 (NA).

²³⁹ Susie, *In the Way of Our Grandmothers*, 45.

²⁴⁰ Mathis, “Lay Midwifery in the Twentieth-Century American South,” 22.

the white physicians were unfamiliar with the midwife network, but black physicians knew of them and expressed hostility toward the idea of licensing because they thought of them as competition.”²⁴¹ Dr. Whipper was more successful in locating midwives when she went through the black church. She asked black ministers to announce meeting times and places from their pulpits. She also contacted groups of black church women, and with them of her “mission” to educate midwives. “Whipper moved very slowly with a new group. She reported that upon initial contact she worked to ‘assure and reassure them that I would not injure a hair in their heads.’”²⁴² In addition to reassurance, Whipper’s teaching style appears to have been effective.

Whipper used a methodology which did not depend upon literacy skills. She showed the midwives the correct practices, meaning those which promoted aseptic conditions, and she had them imitate what she did. This became the basis for her teaching syllabus. In general Whipper used a question and answer format in her classes.²⁴³

Like Pillars, Dr. Whipper had a style of teaching that incorporated direct and simple methods of communication. It does seem possible that their racial identities and their understanding of rural Southern communities gave them a perspective that was more in tune with the traditional midwives. While some medical officials who were working with midwives appear to have been met with resistance, it appears that others who were willing to work in a more direct and intimate manner with the midwives were more successful in promoting the goals of the health departments in the South.

In Mississippi, the initial contact with midwives was followed up with the formation of midwife clubs in each county. The purpose of the clubs was to facilitate continued training and supervision. They were intended by the health officers to be a vehicle for surveillance.

²⁴¹ Ibid., 25.

²⁴² Ibid., 28.

²⁴³ Ibid., 30.

Midwives were asked to give demonstrations of their work, and to present their midwife bags for inspection during club meetings. Each midwife club elected a leader and a secretary who were trained by the public health nurse to maintain a certain procedure for the meetings after the initial instructions were given. After these initial training sessions, midwives in Mississippi were able to assert leadership roles in their groups. Club meetings became social and spiritual gatherings.²⁴⁴

The clubs were monitored closely or loosely depending on the presence of medical authorities in the county. If there was a nursing service in the county, then they would monitor the midwife clubs. If there was not, then the club meetings were monitored from the nearest health department. In all counties the midwife club leaders were to be sent written instructions as to what aspects of midwife work they were to “study” in their meetings. The midwife club leaders were instructed to send back written reports of their meetings. According to the medical authorities of the state, “midwives were made to feel responsible for the success of the club.”²⁴⁵ There is a good amount of evidence that many midwives willingly attended meetings and that they traveled great distances over rough terrain to be in attendance. By one author’s account, “one midwife, a mother of seventeen, rode thirty miles on horseback,” and a “seventy-year-old women walked five miles in the freezing rain.”²⁴⁶ In addition one Mississippi nurse observed that a sixty year old midwife who had to walk eight and a half miles to a meeting arrived before she had. The nurse traveled by car, but arrived late due to bad roads and mud.²⁴⁷

²⁴⁴ Susan Smith, *Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890–1950* (Philadelphia: University of Pennsylvania Press, 1995), 128–129. Molly Dougherty argues that the midwife clubs had a similar structure as black religious organizations in the South, and that for the midwives they were an “integration of the familiar and the strange.” See Dougherty, “Southern Midwifery and Organized Health Care: Systems in Conflict,” *Medical Anthropology* 66 (Spring 1982), 119.

²⁴⁵ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health.”

²⁴⁶ Ladd-Taylor, 182-3.

²⁴⁷ *Ibid.*

The midwife leaders were instructed to hold meetings once a month. The club leader was expected to preside over the meeting, inspect the bags of the other midwives in the club, teach them the official midwife song, and send in regular reports to the nearest department of health. The secretary was expected to check the attendance of the midwives of the club, keep the minutes of each meeting, read the midwife manual aloud to the members, and help with all written work, such as filling out birth certificates and writing reports of the meetings.²⁴⁸

Public health nurses and doctors who recognized the importance of organized religion in the work of the midwives of the South were often the most successful in the first attempts to contact and organize existing networks of traditional midwives in their region. Several aspects of supervision were organized around the acceptable aspects of midwife belief systems: those that involved the Christian church. In South Carolina, the public health nurse in charge of midwife supervision made announcements at the local African-American churches requesting all active midwives to meet with her at their church on a certain day.

The nurse has often been agreeably surprised at the number who would respond to her first call. After a trial of this method, one nurse reports that instead of her rounding up the midwives, they round her up, appearing as if by magic from the woods, and surrounding her car when she stops by chance at a cross road. The midwives themselves bring in the few stragglers who do not voluntarily appear at the first meeting.²⁴⁹

In North Carolina the active midwives in each county were called to meet at their local churches in order to be registered by the state public health nurses. The initial meetings were held in 1925. At one of these initial meetings, 102 active midwives were in attendance. They claimed to have delivered 1326 babies the previous year between them. These meetings were

²⁴⁸ Mississippi State Board of Health, "The Relation of the Midwife to the State Board of Health."

²⁴⁹ Ruth Dodd, "Midwife Supervision in South Carolina," *Public Health Nurse* 12, no. 10 (October 1920), 864.

followed by training sessions, licensing, and organization into smaller midwife clubs. Less than half of the original group of 102 was licensed after the investigations and training.²⁵⁰

The majority of midwives in Mississippi who had an active practice were deemed by the health officials there to be fit to practice. Of the approximately 5,000 midwives who were investigated, 4,209 were granted permits to practice.²⁵¹ The investigation of each midwife included an inspection of her “personal character and general intelligence” as well as “cleanliness of her person, her home and her midwifery equipment,” her standing and reputation in her community and her history of willingness to contact a physician on an abnormal case.²⁵²

Eliza Pillars held regular countywide meetings in order to renew midwife permits and provide special instruction. Her lessons were given in the homes of midwives, at local churches and the board of health offices. Active midwives were encouraged to attend club meetings regularly and to bring their prenatal cases with them in order to spread prenatal health care information. In Mississippi, Alabama, and other Southern states, an individual record was kept of the activities of each registered midwife in the state. These midwife record cards were intended to document meetings attended, inspections made, and other activities that the midwife was involved in.²⁵³

The midwife supervision programs of the 1920s were influenced by the spirit of optimism and social obligation that were a characteristic of the post-World War I ideology. Nurse Reid, the U.S. public Health Nurse who made her proposal for the supervision of midwives in Mississippi in 1921, declared that the work of training midwives in Mississippi was more valuable in 1921 than it had been in any other time in history. “Our time has come to do our share toward

²⁵⁰ Mongeau, “The ‘Granny’ Midwives,” 44.

²⁵¹ Mississippi Department of Health, “Midwife Supervision: Statewide Survey.”

²⁵² *Ibid.*, 103.

²⁵³ *Ibid.*, 105–106.

upbuilding of a race of strong, healthy, well balanced, keen minded men and women.”²⁵⁴ In particular she pointed to the necessity of birth registration to prove citizenship through birth records during the war. Birth registration should be considered a moral and patriotic duty for physicians, and especially midwives who had previously been guilty of neglecting this area of service. Reid compared the work of midwife training with that of a soldier fighting in the war.

If you can help to prevent the wastage of maternal and infant life, or save only one baby from blindness, you will be as truly serving your country as the man who died in the trenches, or those who wear the Nation’s badge of honor.²⁵⁵

Public health nurses such as Reid working with African-American midwives in the South were motivated by the postwar spirit of reform and social uplift. Reid was also reflecting the maternalist trend in public health reform work that has been discussed earlier in the chapter. Public health reform movements of the 1920s carried the intention of improving the mother’s ability to produce healthy infants and children.²⁵⁶ The midwife supervision plan for Mississippi was an extension of this ideology, as midwives were expected to educate childbearing women as to proper prenatal and postnatal care. In this way, African-American midwives were held directly responsible for infant health as well as responsible for infant and maternal deaths.

Some state and national health-care workers in the 1920s were antagonistic toward the traditional midwife. Jessie Marriner, director of the Child Hygiene and Public Health Nursing department of the Alabama State Board of Health during this time, was effective in articulating a more oppositional perspective on midwife regulation work in the South:

²⁵⁴ Reid, “Plan of the Mississippi State Board of Health,” 178.

²⁵⁵ *Ibid.*, 181.

²⁵⁶ Richard Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Baltimore: Johns Hopkins University Press, 1990), 5–6.

The crux of the problem is the midwife herself and the record of what happens to her patients. A successful program of midwifery control means a firsthand knowledge of the “problem.” Constant contact at least once every month with individuals and groups in an effort to teach them as much as possible and to check up as closely as possible on their activities is essential to a knowledge of the problem.²⁵⁷

The “problem,” in Marriner’s view, was the traditional midwife. Marriner described the midwives in her state as “ignorant, well meaning, not very clean negro women whose most cheerful aspect is the fact that they only occasionally do midwife work.”²⁵⁸ Her perspective did not take into account the lack of formal educational opportunities for the midwife, or the system of racial segregation that had kept African-American childbearing women out of most hospitals in the South. The problem was identified by Marriner and other health officials as the figure of the midwife. W.E.B. Du Bois explores this phenomenon in *The Souls of Black Folk*, written a little more than a decade before. As Du Bois argues in his essays, African Americans were perceived by the white majority as the American “problem.” Like Du Bois, they may have asked themselves, “Why did God make me an outcast and a stranger in mine own house? The shades of the prison-house closed round about us all.”²⁵⁹ Midwives were expected to perform only rudimentary procedures, and had access to a meager list of acceptable materials. They were held responsible for the maternal and infant health of the entire black South, yet according to Nurse Marriner they were the problem. In characterizing midwives as a “problem,” Marriner was also expressing an anxiety over racial and ethnic difference that was not uncommon in maternalist reform efforts.

Maternalist reformers of the early twentieth century were not immune from the common racial assumptions of their time period. They conflated good health care with the Anglo American middle class model of childbirth. As historian Molly Ladd-Taylor has explained:

²⁵⁷ Marriner, “Midwifery in Alabama,” 131.

²⁵⁸ *Ibid.*, 130.

²⁵⁹ W.E.B. Du Bois, *The Souls of Black Folk* (Chicago: A.C. McClurg & Co., 1903).

Sheppard-Towner promoted ideas about science and medicine that were rooted in the cultural beliefs of the Anglo-American middle class. Bureau officials tried to save lives by providing up-to-date medical care to women of color and suppressing what they considered the superstitious and dangerous healing practices of immigrants and African Americans.²⁶⁰

Further evidence of their cultural bias was that Children's Bureau officials ignored their own conclusions as to the causes of infant mortality. Earlier in the chapter it has been discussed that studies conducted by the Bureau had found a direct link between a low income of the father, extensive work history of the mother and an elevated infant death rate. Surely, health officials were able to observe the extreme physical demands on women throughout the rural south. As historian Molly Ladd-Taylor has documented, "a great many of pregnant women worked right up until delivery. In rural Mississippi, for example three fourths of the white and almost all of the black women in one sample did housework and laundry while they were pregnant."²⁶¹ The majority of black women worked in the cotton fields in addition to their domestic duties. In one example, "a North Carolina mother of five picked forty-five pounds of cotton and cooked a big dinner for her family the morning her baby was born."²⁶² While it was clear that African American mothers were under tremendous physical strain and had a low level of access to prenatal care information, the discursive focus of programs for the African American community was on the "superstitious" "ignorant" and "unclean" practices of Black midwives.²⁶³ It is my contention that the racial anxiety of health officials is what caused the disharmony between the evidentiary findings and the programs established through the Sheppard-Towner Act.

The teas that had been so central to the experience of childbirth for African American women were difficult to part with for the midwives and mothers of the South. According to historian

²⁶⁰ Ladd-Taylor, 180.

²⁶¹ *Ibid.*, 21.

²⁶² *Ibid.*

²⁶³ *Ibid.*, 182.

Molly Ladd-Taylor some traditional rituals remained during and after the period of regulation. In particular, “they continued to use herbal treatments, favor traditional birth positions, and follow established rituals, such as placing a knife under the bed to ‘cut the pain’ and burying the placenta.”²⁶⁴ By refusing to abandon certain traditional ways they played a role in defining the birth experience throughout the period of regulation.

The negative view held by health officials regarding the traditional practices of midwives were a product of a vast cultural gap, as well as the goals of professionalism. According to medical historian Jane Pacht Brickman, health officials had two primary concerns in the early twentieth century. “First, they sought a general improvement in American health standards. They hoped to challenge high rates of disease and death with the promises offered by the universal application of modern medical technology and the germ theory. Second, they endeavored to set their house in order – to unify the profession to assure members both public acknowledgement and financial security.”²⁶⁵ African American midwives were considered a threat to both goals. In the case of the first, they were held responsible for the elevated infant and maternal mortality rates in their communities and other related complications of birth. According to turn of the century physicians, midwives, “bore responsibility for the frequent gynecological surgery following unattended childbirth lacerations, and for the prevalence of blindness from ophthalmia neonatorum (caused by gonorrheal bacteria, which the infant contracts in passage through the birth canal).”²⁶⁶ In terms of the second goal, the African American approach to childbirth was oppositional to the medical model.

²⁶⁴ Ladd-Taylor, 183.

²⁶⁵ Jane Pacht Brickman, “Public Health, Midwives, and Nurses, 1880-1930,” in *Nursing History: New Perspectives, New Possibilities*, ed. Ellen Condliffe Lagemann (New York: Teachers College Press, 1983), 67.

²⁶⁶ Brickman, 69.

Midwives offered care that stressed indigenous and holistic qualities, again exemplifying an approach that had become anathema to the medical profession. Unlike Obstetrics, midwifery was not organized around a pathological model...the germ theory proved vital to the medical profession's new self determination and public image.²⁶⁷

The medical model of childbirth elevated the reputation and financial security of the physician. Their ultimate goal was to educate the public as to the skill and necessity of the physician during childbirth, so that the public would recognize "such a thing as the 'science and art of obstetrics.'"²⁶⁸ This was considered preferable to training the midwife and potentially elevating her status. The midwife's "casual approach to obstetrics," contradicted the medical approach, but the repercussions were far more severe. "They threatened American Medical Associations (AMA) efforts for professional homogenization, designed to extirpate nineteenth century elements of multiplicity of practitioners, educational standards, and fee scales, which had been so detrimental to professional prestige and practice."²⁶⁹ The two sides were oppositional in their approach and ideology of the birth experience. One midwife responded when asked what she did when she arrived on a case, in such a manner: "Honey I don' do nothin': I jus' lights my pipe and waits."²⁷⁰ This remark is indicative of a method of downplaying the midwife's role in the birth experience. As discussed in the previous chapter, it was common for midwives to highlight the role of the Devine Being over her own. On the other hand, physician's relied on modern scientific theories and used drugs and medical instruments to rush the labor process.²⁷¹ In terms of approach their was very little common ground between the lay midwives and the health professionals of the early twentieth century.

²⁶⁷ Brickman, 75.

²⁶⁸ Ibid., 70.

²⁶⁹ Ibid., 67.

²⁷⁰ Ladd-Taylor, 24.

²⁷¹ Ladd-Taylor, 24.

Health professionals claimed that the midwives who continued to use the traditional methods posed a physical threat to the mother and baby. The midwife reform program of the twentieth century reflected a strong underlying thread of racial and cultural bias against folk practices in the South and elsewhere. The consistent use of language such as “ignorant” and unclean to describe the midwife points to racial and class bias. Reid, as pointed out in the opening of the chapter, described the midwives in her state as “illiterate, ignorant, negro women, without the knowledge of the first principles of ordinary soap and water cleanliness.”²⁷² This type of language appeared repeatedly in the records of state and national health organizations. The focus was always on the perceived “ignorance” and “uncleanly” nature of the midwives. In a 1920 article in *The Public Health Nurse*, Ruth Dodd describes the midwife situation in South Carolina as a “most difficult and gigantic one, when we consider that twenty per cent of white mothers, and eighty per cent of colored, depend upon dirty, ignorant negro women for care at a time when they should have the most skilled attention.”²⁷³ A report of the United States Department of Labor made in 1927 describes the type of midwives that they were trying to replace as “the old, unfit, the diseased, ignorant, superstitious, and dirty....”²⁷⁴ A year earlier, Jessie Marriner, the director of Child Hygiene and Public Health Nursing in Alabama, had made the statement quoted earlier that after conducting personal interviews she found that 75 per cent of the midwives in her state were “ignorant, well meaning, not very clean negro women....”²⁷⁵ The discourses of the medical establishment reflected a complete lack of understanding for the cultural position and viewpoint of the childbearing population they were working with.

²⁷² Reid, “Plan of the Mississippi State Board of Health,” 176.

²⁷³ Dodd, “Midwife Supervision in South Carolina,” 863.

²⁷⁴ U.S. Department of Labor, *Promotion of the Welfare and Hygiene of Maternity and Infancy*, 20.

²⁷⁵ Marriner, “Midwifery in Alabama,” 130.

In *Tuskegee Truths*, Susan Reverby states that in order to fully understand the significance and meaning of the Tuskegee syphilis study, “we have to examine the historically specific ways race as a social category has been both created and creates differing kinds of medical assumptions and practices.”²⁷⁶ Similarly, the work with traditional midwives was informed by race as a social category, as well as deeply held notions of class and geography. Traditional rituals were deeply associated with black, rural, agricultural communities, and were therefore culturally alien, misunderstood, and maligned by health officials who tended to be more vocal on a state and national level.

Records from five years after this first organizational meeting showed that the “experienced group,” who had been the most popular before the regulation and training period began, continued to be the most popular. Those among the younger group who had had some experience prior to state intervention were described as “showing promise.” And those who had had no experience prior to state-run training programs were not busy and considered unsuccessful in their attempt to establish themselves as midwives in their community.²⁷⁷ The childbearing women in this North Carolina community did not appear to be influenced by the biases of health organizations, which preferred younger more professionally trained birth attendants. In a published report made by the U.S. Department of Labor in 1927 this preference seems clear:

In a number of States classes were conducted by nurses and by physicians.... [S]ome negro graduate nurses have attended classes and qualified as midwives. The old, unfit, diseased, ignorant, superstitious, and dirty midwives are being eliminated, and a better type of negro midwife is being developed.²⁷⁸

²⁷⁶ Susan Reverby, “More Than a Metaphor: An Overview of the Scholarship of the Study,” in *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study*, ed. Susan Reverby (Chapel Hill and London: University of North Carolina Press, 2000), 3.

²⁷⁷ *Ibid.*, 502.

²⁷⁸ U.S. Department of Labor, *The Promotion of the Welfare and Hygiene of Maternity and Infancy*, 20.

Some of the midwives expressed a preference for the traditional forms of recruitment.

The experienced midwives ... looked askance at the new young recruits: One just didn't go out and deliver babies, trained or not. Such positions were attained through proper channels, through family succession, or, occasionally through divine appointment, but only then after long years of experience and hard work.²⁷⁹

The precise reasons for childbearing women's preference for elder midwives are unclear. It is clear, however, that a midwife who had a certain amount of experience and training from her predecessors would have a good body of knowledge in folk methods of healing. Testimonies by some childbearing women showed a preference for the traditional healing methods. Margaret Charles Smith, a midwife who practiced in Alabama for many years under state regulation, indicated in her biography that "some midwives even doubted that some of these rituals actually had medical credibility, but the mothers requested them--so they performed them mostly to provide comfort and a sense of well being for the mothers."²⁸⁰ In the following account, a midwife from North Carolina describes her use of traditional healing rituals and her doubts regarding the ritual of placing a sharp instrument under the bed of the mother to relieve her pain.

I wondered sometime how the ax could do much good when it didn't even touch the mother. The doctor said it didn't, but the mothers said it did. I wasn't sure, so I put it there anyhow, just in case.²⁸¹

Because midwives were not regularly supervised during a birth, they were able to use any and all techniques that the circumstances called for. Often, they relied on folk healing methods when faced with a complication. They relied on methods such as the use of black pepper to expel the

²⁷⁹ Mongeau, Smith, and Maney, "The 'Granny' Midwife," 502.

²⁸⁰ Smith and Holmes, *Listen to Me Good*, 40.

²⁸¹ Mongeau, "The 'Granny' Midwives," 57.

retained placenta of the woman in the previous example, because they had no medical alternative at hand. Others were used because the mothers relied on them for emotional reassurance. As stated by Smith, “some women preferred the untrained birth attendant.”²⁸² During her own pregnancies, Smith questioned the use of some teas that were given her by older midwives. However, “she complied with her grandmother’s instructions. The prescriptions of her grandmother and other ‘old heads’ in the community required no justification, for these women were seen as ‘wise women.’”²⁸³

The degree to which African-American midwives of the South embraced or rejected the process of supervision was often dependent on the particular approach, personality, and relative social position of the nurse in charge. A nurse in charge of the early stages of midwife supervision in South Carolina was “agreeably surprised” by the number of midwives who responded to her request for an initial meeting to arrange supervision and training. She had approached the midwives through “the cooperation of local registrars, ministers and deacons of the colored churches.”²⁸⁴ Another nurse working in the state used a more forceful approach.

A colored nurse was employed by the bureau to work in the southern counties of the State where the population is largely colored, and where practically no Public Health Nurses are employed. As there was no specific legislation governing midwives, registration was voluntary this first year. Since the initial, when the midwives of one town refused to register, and the colored nurse, on her own initiative enlisted the services of the local registrar and policeman to round up the group--a class of twenty---no difficulty has been experienced in the formation of classes in the fifteen counties where public health nursing services are organized.²⁸⁵

The midwives of St. Helena’s island resisted the initial attempts at registration. The island was populated, at the time, exclusively by the descendants of slaves. They were described by a

²⁸² Smith and Holmes, *Listen to Me Good*, 64.

²⁸³ *Ibid.*, 43.

²⁸⁴ Dodd, “Midwife Supervision in South Carolina,” 864.

²⁸⁵ *Ibid.*, 863.

nurse in the area as being “superstitious,” and would not meet for registration because the nurse who had been in charge of registration was “mulatto.” She was “shunned by the island negroes because they said she was born of sin and sent by the devil.” When they found out that the new nurse was a black woman of darker complexion, they eagerly gathered to meet her and said that “God sent her.” Thirty-three midwives met the new nurse at the first meeting, and the number quickly grew to forty-five. The enthusiasm of the midwives to receive instruction was demonstrated by their “prompt attendance, some coming miles to the class.”²⁸⁶ The success of the first nurse was followed by that of another black nurse from a nearby medical school.

Following up the cases in their homes she reports that midwives use the boric acid solution for babies’ eyes, also that they are more careful in a general way, as well as cleaner.²⁸⁷

Midwives who were part of the regulation movement showed appreciation for African-American nurses, whom they felt had made medical information more accessible to them. In 1934, a midwife club leader in Mississippi wrote in her report to the state department of health that, “we pledged to do better this year and are so thankful for those splendid colored nurses you sent us in June and hope some day they will come again. They made it so plain that even the person that can’t read can understand.”²⁸⁸ The ability of the nurses to “make it plain,” is what was most appreciated by the members of this midwife club. The instructions were presented in a manner that was accessible, tangible, and not intimidating to the midwives of this community. Traditionally, midwives believed that their most important instructions were received through visions and from direct communication with God. The fact that these nurses made the message “plain” just as God had spoken to them in a way that they could understand meant that midwives

²⁸⁶ *Ibid.*, 867.

²⁸⁷ *Ibid.*, 863.

²⁸⁸ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health.”

could relate easily to the instruction. The nurses who used this method of instruction were often revered by the midwives. They had almost a divine association. Midwife clubs in Mississippi often spoke of wanting to impress their instructors with the success of their health work. In the annual report from the Lee County Midwife Club in 1937, the secretary of the club, Lillie Bell Hill, reported that, “through the help of the white nurses, we have improved our people one hundred per cent.... [T]hrough the health department, doctors, and nurses, we have been brought to light and are so thankful that we try to keep this in mind.”²⁸⁹ In this report, Hill shows a clear appreciation for the instruction her group had received for the reason that it had improved the health of the women in her community.

Despite the enthusiasm and adaptability of certain groups of organized midwives, local and national health officials were unanimous in their efforts to curtail the role played by midwives in the South. The emphasis remained on control. Health officials had hoped they would be able to achieve in rural areas what had taken place in urban centers of the South such as Birmingham, Alabama:

When Alabama’s amended state law regulating midwife practice became effective in January, 1920, the city of Birmingham instituted classes for the midwives then licensed in the city. After a discouraging year of weekly classes, giving instruction in prenatal, maternity and infant care, it was decided to eliminate the midwife as far as possible from the city. The few who continued to practice contrary to instructions were prosecuted.... [E]fforts were made to enlist the interest and cooperation of physicians in communities where midwives were extensively employed. The physicians agreed on a minimum charge for delivery, while prenatal care was provided through volunteer medical service in a community clinic and by a visiting nurse service.²⁹⁰

The extension of this type of program into more rural and isolated areas was considered, but was not possible because the necessary medical services were not available: “[E]limination (of

²⁸⁹ Lillie Bell Hill, “Annual Report for Lee County Midwife Club,” 1937 (MDAH, RG 51, Loc 11-19-1, Box 8407, 1012).

²⁹⁰ Rude, “The Midwife Problem in the United States,” 989.

the midwife) has been effective in its results only so far as medical and nursing facilities have been substituted for the untrained midwife.”²⁹¹ It is clear that the larger number of practicing health professionals in the urban South made the experience of childbirth very different for urban women versus rural women. However, it may also have been the case that these women, living in an urban area, had a greater level of exposure to modern medicine, and were more comfortable with it. It is also possible that the traditional rituals and religiosity of childbirth practices that were maintained in the rural areas had been disrupted by the urban lifestyle and environment, and therefore urban women may have been more adaptable to changes in childbirth practices and caregivers. For many reasons, the experience of childbirth in the rural areas of the South was quite different from the experience in the urban South. Rural health-care workers were unable to eradicate the use of midwives among women in these communities.

The traditional folk practices of midwives were, according to the medical discourses of childbirth, the antithesis of modern techniques, and professionals wished to replace them with techniques and instruments that reflected a more modern and secular approach to childbirth.

Nurses occasionally took credit for transforming a group of traditional midwives.

Beside a little kitchen table borrowed for the occasion stood the nurse with the demonstration materials. In front of her were arranged the twelve “mammies,” each resplendent in garb of snowy cap and gown, and each bearing proudly a little black bag to be presented to the nurse for inspection. The opening of these bags revealed an interior perfect in detail of equipment--white cotton lining, nail brush and file, germicidal soap, scissors, hemostats, Norwich Obstetrical package, which contains sterile gauze and tape, ampule [*sic*] of nitrate of silver and package of boric acid--the whole conspicuously free from superfluous articles. One by one they stepped up to the table and with all the poise of a professional, demonstrated the assiduous scrubbing of the hands and cleaning of nails; the preparation of a maternity bed; the bathing and dressing of a baby.²⁹²

²⁹¹ Ibid.

²⁹² Ruth Dodd, “An Open Air Class,” *Public Health Nurse* 13, no. 5 (May 1921), 289.

It was important for the nurse to demonstrate that she had been able to markedly detach this group of women from the traditional practices and images of midwifery. The nurse claimed that “many of the old-time superstitions were scornfully laughed at, as entirely beneath” this group of highly trained midwives. The detailed list of materials carried in the midwife bag was meant to promote the idea that they used these materials only and had abandoned the use of teas and ritual objects. They have been replaced with sterile medical supplies. This article was written in 1921, the same year that midwife regulation programs were initiated in most Southern states. It reflected the initial enthusiasm among nurses to transform the practices of midwives.

Other nurses were not as confident in their ability to successfully transform the practices of midwives. A nurse working in Alabama reported the following:

At her best the midwife is teachable in that she can learn the lessons presented to her and recite them, but whether she practices them when not under strict observation is something no one is able to say. At her worst the midwife is unteachable, unruly, and vicious and constitutes a serious menace to infant life and the lives of mothers.²⁹³

This statement was made in 1926 and was a common depiction of the challenges of midwife regulation work in mid-decade.

Many of the midwives who were part of this first wave of regulation had received enough training from their elder predecessors that they maintained an ancestral link to traditional practices. Traditional midwives attempted to maintain control over the recruitment and training of new midwives. This is an area in which they were accustomed to having complete control; moreover, it was a sacred process, dominated by spiritual visions and callings. In the traditional system, a successor was shown to them through divine intervention. Since it was linked to the

²⁹³ Marriner, “Midwifery in Alabama.”

spirituality of childbirth, they were unwilling to give up total control over the recruitment process.

Even when health department officials actively were recruiting younger midwives, senior midwives repeatedly denied certain recruits from observational experience if these women failed to meet their standards of eligibility for midwifery work. Having good nerves, demonstrating spiritual commitment, actively attending births in the community over an extended period of time, exhibiting moral behavior which was in keeping with senior midwives' own personal values, and having a midwifery family lineage were among the most frequently cited by senior midwives in assessing potential for midwifery success.²⁹⁴

The midwife regulation programs of the South reflected the class biases of health workers. Midwives were trained to appear more like middle-class health workers, yet were not taught modern medical techniques. Their training was rudimentary and redundant. However, they continued to expand their health work in ways that fit within the confines of their surveillance. In the public arena of midwife club meetings and health department activities, they emphasized and utilized their position in the Christian church. Within the private arena of the birth room, they maintained traditional practices that were preferred by mothers. They continued to explore ways to include God's presence in their work throughout the second half of the twentieth century. It was not until African-American childbearing women began to associate midwife work with inferior medical treatment that midwives began to lose their positions of authority.

Throughout the 1930s and 1940s, African-American women midwives extended the type of health work they performed in their communities. Midwives utilized their status as spiritual leaders to spread health-care information. Midwives in Mississippi, who worked under strict guidelines and close surveillance, had by the 1930s created ways to utilize the medically acceptable aspects of their faith to do effective health work. They worked through their

²⁹⁴ Holmes, "Medical History: Alabama Granny Midwife," 390.

churches. Mollie Gilmore, a midwife in Warren County Mississippi recorded that on September 6, 1936 she spoke at her church and led a prayer for the congregation. Several days later she was at the church again with the local physician to assist in administering a second round of vaccinations to the community. She continued to spread health information throughout her community. She recorded that “then I began to talk and talk, and up to December 29th had talked to 100 different people in prenatal care, and health and care of the baby.”²⁹⁵

Midwives encouraged their ministers to participate in their health campaigns. Ministers gave health sermons from their pulpits and spoke at midwife gatherings. Mollie Gilmore noted that at her local May Day celebration ministers, physicians, and midwives all participated to spread health information.

Our gathering was mostly midwives and children. We had a health sermon preached by Rev. Robson, a talk on tuberculosis by Dr. F.E. Pinson, a talk on syphilis by Dr. J.B. Dillard. Children sang songs. Many prayers and remarks were heard and read.²⁹⁶

Ministers were asked to speak at midwife club meetings. Lillie Bell Hill, secretary of her midwife club in Lee County, Mississippi, reported that the lecture given by her minister inspired the midwives of the group to have a “new thought” and a “new mind to understand the manual and get more out of it.”²⁹⁷ The midwife manual was often referred to as “The Book,” and was considered a sacred text by the midwives. Each midwife meeting included reading passages of the manual followed by a discussion.²⁹⁸ The nurses who organized and supervised the midwife clubs of the South had intended for them to include prayer and other Christian traditions.

²⁹⁵ Mollie Gilmore, “Report of Work of Mollie Gilmore, Midwife, for July 1936 to December 1937” (MDAH, RG 51, Loc 11-19-1, Box 8407).

²⁹⁶ Ibid.

²⁹⁷ Hill, “Annual Report for Lee County Midwife Club, 1937.”

²⁹⁸ Susan Smith includes discussion of midwife club meetings in her chapter on midwives in Mississippi. Smith, *Sick and Tired*, 128–29.

However, midwives were able to choose for themselves the passages of the Bible to read, and which pastor spoke at which meeting. They organized the spiritual aspects of meetings to reflect their own beliefs regarding the role of God in their work.

Prayer was a regular part of midwife club meetings. The meetings often would commence with a song and a prayer. The leader of the midwife club in Attala County, Mississippi, recorded that “[t]he midwife club met the first Saturday in January with the leader in the chair, sang and read and then had prayer.”²⁹⁹ A similar format was followed by the midwives in Carlisle County, Mississippi. The secretary of the club recorded, for a meeting in 1942, the following: “The house was called to order by the leader of the club at 11:30, song sung by one of the mothers, Louise, prayer by the secretary. Now the house is ready for business.”³⁰⁰

When the practices of midwives in Mississippi were surveyed in 1920, it was found that 99 percent of the practicing midwives in the state were African-American women who were described as elderly, superstitious, and generally lacking in the necessary skills for practice.³⁰¹ This image was used to convince the medical community that these women needed to be taught to abandon their traditional practices. The nurses and doctors of Mississippi who advocated reform focused on the issues of “superstition,” illiteracy, and lack of cleanliness in their campaign to enforce strict midwife supervision policies. In South Carolina, physicians and nurses worked together to reform the birth practices of the rural black population through targeting the midwives in their state:

The physicians enter heartily into the effort to improve the cleanliness and technique of these old “mammies” whose services cannot be entirely disposed with. Miss Rines’ diligence had

²⁹⁹ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health.”

³⁰⁰ Julia E. Lucas, “Midwife Club Report, Claiborn County” (MDAH, RG 51, Loc 11-19-1, Box 8407).

³⁰¹ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health.”

ferreted out twelve old “mammies” who, with all the art of old time superstition, practiced midwifery upon the rural inhabitants of the district.³⁰²

These women were meant to be replaced with midwives who were more in keeping with the modern philosophy of childbirth. With the backing of national health organizations, such as the U.S. Children’s Bureau, the “better type” of midwife was being developed, who resembled a nurse in appearance.³⁰³ Medical professionals, among others, wanted women who were younger, literate, did not practice any type of folk medicine, and readily absorbed the techniques taught them by the health department. Midwife education programs of the South were meant to train women in rudimentary childbirth techniques. However, the focus often shifted to elevating her class identity and altering her appearance to be more in keeping with what was considered middle-class respectability. According to medical professionals, the “superstitious” practices of the elder generation of midwives were associated with infant death, but also with illiteracy, ignorance, and uncleanness (and thus, lower-class identity).

³⁰² Dodd, “An Open Air Class,” 290.

³⁰³ U.S. Department of Labor, “The Promotion of the Welfare and Hygiene of Maternity and Infancy.”

Chapter Four: Tuskegee University and Efforts to Transform the Practices of Alabama's Traditional Rural Midwives

During the period of the Great Depression, black medical institutions such as Tuskegee Universities' Andrew hospital played an important role in addressing the dire medical concerns of the surrounding, predominantly rural, community. During the first thirty years of the twentieth century, "the health care of neglect of Blacks and their relegation to segregated and inferior facilities became institutional and acceptable."³⁰⁴ In the decade of the 1930's things became worse in the black south where, "studies conducted in the South during the Depression revealed the health effects of diets insufficient to produce normal body weights and to fight off diseases in children."³⁰⁵ There were many health challenges facing the administrators of Andrew's Hospital, however, the Public Health Nurses who were charged with traveling throughout the countryside were told to focus on, "midwives and tuberculosis."³⁰⁶

In 1935 a nurse from the Tuskegee Movable School conducted a series of interviews among the midwives of Clarke County, Alabama. The nurse was trying to determine the level of care that African-American childbearing women were receiving in this rural county. The Tuskegee nurse questioned one midwife about her materials for a delivery, and found that she, "had material etc. that a midwife should have; but she did not have a kit to carry them in, so she put them in a 4lb. Jewel Lard carton."³⁰⁷ Another midwife told the nurse that she carried with her

³⁰⁴ Michael Byrd, MPH and Linda Clayton, MD, MPH, *An American Health Dilemma Vol II: Race, Medicine, and Health Care in the United States* (New York: Routledge) 2002, p. 45.

³⁰⁵ Byrd and Clayton, p.139.

³⁰⁶ J.L. Dent, "Narrative Report of J.L. Dent, R.N. Movable School Nurse," March 1935 (ADAH, Box SG7065, Files of the State Health Officer, Tuskegee Institute).

³⁰⁷ J.L. Dent, "Narrative Report of J.L. Dent," January 1935 (ADAH, Box SG7065).

only “the Lord and olive oil,” that is, she relied on the instructions of Jesus Christ, traditional folk remedies, and common sense that so many midwives practicing without medical intervention had depended on for decades. The midwives in Clarke County had not only been serving their community for many years, but had done it in virtual isolation. They had had little contact with any institution of modern medicine and were forced to rely on their own resources. In the 1930s, many midwives continued to practice, due to the economic hardship of the time in isolation and according to their own belief systems. It is clear that the environment for infant and maternal health work had changed in subtle but significant ways since it was initiated in the 1920s. The period that previous historians of childbirth have referred to simply as that of the “rapid decline” of the midwife was, when investigated closely, one of transitional figures and new forms of accommodation to the surveillance of childbirth practices, that allowed women to maintain certain traditional beliefs about the experience of childbirth.

In an effort to construct a more detailed picture of the types of individuals and personalities who were active in the childbirth experience during this time, I will discuss a series of profiles of midwives who practiced in Talladega County, Alabama, during the time period. The relationship between childbirth and modern medicine had changed from the 1920s. Some individuals were openly resistant, others had the appearance of compliance yet maintained their own traditional forms of practice, and there were still others whose alliances had shifted away from the personal needs of their clients and toward the expectations of health-care workers. In this chapter I will examine the records of several midwives who embodied elements of the traditional midwife, either through their training, methods, or spirit of independence, yet who also accepted state regulations and training. They maintained a role in both worlds of traditional healing practices and modern medicine. However, unlike their predecessors who were able to successfully

navigate these worlds, the practitioners of this time period struggled in their roles, and their ability to successfully care for the women and babies under their care. Their spirit of independence led them to ignore practices taught by the health department that would actually increase the chances of the survival of their patients.

During the period of the 1930's and 1940's, a transitional figure began to emerge. There were examples of women who received the majority of their training from the state and local health departments. Unlike other midwives who have been discussed earlier, they did not have extensive experience working with an elder traditional midwife. They were trained only by the health department. I will discuss the example of Rebecca McGee, a midwife who worked in Talladega County, who worked in a close, partnership like relationship, with the Public Health Nurses who had trained her. This example represents the shifts that were taking place in the history of childbirth among black southern women. Rebecca did not operate with two sets of instructions, as many did who had both traditional and modern training. She ordered her practice in strict keeping with the regulations of her local health department, and she was more likely than others to report the infractions of other midwives.³⁰⁸

As mentioned, Tuskegee University, and in particular the staff of the John A. Andrew Hospital, was particularly interested in the maternal and infant health of the surrounding community. The hospital was founded as part of a movement among African Americans to take responsibility for their own professional advancement. Andrew was part of a, "burgeoning Black hospital movement," that began at the turn of the century and was full fledged by 1930. It was, in part, a reaction to the Jim Crow laws of the South. "African Americans established, against great odds, teaching hospitals and postgraduate training programs" such as the John

³⁰⁸ "Rebecca McGee" (ADAH, Talladega County Midwife Record Cards, Records of the State Department of Health).

Andrew clinic so that they could train their own, and, in addition, address the growing health needs of the surrounding communities.³⁰⁹ Their agenda in regards to maternal and infant health: to reach out to the surrounding community, gather information, and provide informal instruction and training to midwives and mothers. The Andrew clinic was founded in the spirit of uplift and self help. Their maternal and infant health programs carried the same spirit. The staff of Andrews was interested in alleviating the suffering of the community. However, in addition, they were attempting to transform the image of the black birth. This point will be discussed in this as well as the following chapter.

African American infant and child mortality rates had seen a gradual decrease throughout the course of the first half of the twentieth century. While there were still many health challenges facing African Americans, there was some improvement in child and infant health. In 1900 one child in four died before the age of five. In 1940 the rate was one in ten.³¹⁰ The average national rate of decline in this period was 2.7 percent. Despite this improvement, the black infant mortality rates continued to be markedly worse than their white counterparts. In 1910, the black rate was twice that of the white: 261.6 per 1,000 births compared to 129.7 per 1,000 births. In 1933 the rates had improved, but again there existed a racial disparity. The black rate was 85.4 compared to 52.8 for white births. In 1944 the black infant mortality rate was 67.2 and the white was 39.2.³¹¹ These figures may serve as a partial explanation for the assertiveness of the African American nurses and doctors who worked at the John A. Andrew hospital to maintain their commitment to maternal and infant health.

³⁰⁹ Michael Byrd, MD, MPH and Linda Clayton, MD, MPH, p. 130.

³¹⁰ *Ibid.*, 157.

³¹¹ *Ibid.*

In the 1940s, public health officials often asserted confidence in their ability to control the population of midwives. They articulated successes in weeding out midwives whose practices were considered to be most life-threatening to mothers and babies, and in recruiting younger and more literate women to be midwives who were thought to be easier to control. In a 1941 report, one nurse argued that “the number of midwives among the negro population should be kept at a level to take care of the existing need.”³¹² She determined that for this particular county, the number of active and registered midwives should not fall below forty. The health department in Macon County actively worked to reduce the number of practicing midwives. “The Department has carried on a vigorous campaign to eliminate those who are both unfit and uncooperative.”³¹³ Despite this statement, there was a group of women who continued to practice despite outright refusals to adhere to health department regulations. There were also cases of disagreement between the nurses and physicians in charge of maternal health programs.

The tensions that arose in this county during the 1940’s signal a shift in the relationship between the black experience of childbirth and modern medicine. As we will see from the records kept on midwives in Talladega County, Alabama, there existed a multiplicity within the craft. Some women were vigilant, clean, and orderly in their manners and appearance. Others were unkempt, disorderly, and more likely to find ways to divert the attention of the nurses in charge of midwife supervision.³¹⁴ The trajectory from home to hospital birth was not a smooth line, but a rough, jagged, zigzag. There were advances in the infant mortality rates of African Americans, but this did not necessarily signal an overall shift towards hospital or physician

³¹² A.H. Graham and A.S. Dix, “Appraisal of Health Services in Lee County, AL,” 1939–1941 (ADAH, Box SG14437, File “Department of Public Health Records, Reports and Surveys on County Health Programs”).

³¹³ *Ibid.*

³¹⁴ ADAH, Talladega County Midwife Record Cards, Records of the State Department of Health.

attended births. In 1937, 35 percent of Southern African American babies were delivered by a physician (compared to 90 percent of white babies). In 1940, 52 percent of infants in the United States were delivered in hospitals. The white proportion, 56 percent, was more than twice that of the black proportion of 22 percent.³¹⁵ In the South, unlike the period of enslavement or even the late nineteenth and early twentieth centuries, there was a greater disparity between southern black birth routines and those of white southerners who had by this time embraced, and been embraced by modern medicine. The opposite was true for black women. Yet, they found ways to improve their outcomes. There was a connection to modern medicine, and this in part explained the advances, but it was a tenuous, interrupted, and fragile connection.

Throughout the 1930s and 1940s, midwives, when asked to identify the types of labor they performed, stated that they worked in health care, agriculture, and domestics. When the nurses working in Talladega County arrived at the home of one of the midwives under their supervision, they often found them working in the home or in the field. One midwife, Eliza Grace, was “found sewing” in her home that the nurse described as “clean.” On another visit, Eliza was “found out in the field chopping cotton when the nurse arrived.” She missed a meeting at the health department in 1940 because she was “busy in the field,” and another in 1941 because she was “out on a case.”³¹⁶ This record demonstrates the various types of work a midwife was likely to be engaged in at any given time. They bounced back and forth between work in the field, housework, and delivering health care in their communities.

A variety of conditions regarding prenatal care and the instruction of midwives existed in various parts of the South in this time period. In some areas, midwives were more independent

³¹⁵ W. Michael Byrd, MPH and Linda A. Clayton, MD, MPH, p. 158.

³¹⁶ “Eliza Grace” (ADAH, Talladega County Midwife Record Cards, Records of the State Department of Health).

and preferred to treat most conditions on their own such as early-term deliveries and miscarriages, despite warnings from the health department. There was also growing group of midwives who recognized that their patients would benefit from at least one visit to a medical professional during the prenatal period. The nursing staff was unable in some areas to do more than loosely monitor the work of midwives. Nurses often would focus their efforts to have the greatest impact on the maternal health of their county. For example, in 1932, the Macon County health department nurse recorded that:

The bulk of the practice is done by 33 midwives while 61 attend only occasional cases. A large percentage of the stillbirth deliveries occurs in this group of 61.... [I]t seems, in view of the findings, that instruction could be concentrated in those midwives attending the most cases, and that the remainder could be gradually weeded out.³¹⁷

The approach and effectiveness of midwife campaigns varied from county to county, depending on staff numbers.

Tuskegee University, through the services of their midwife training programs, the Tuskegee Movable School, and the nurse-midwife training program, was deeply involved in efforts to transform the birthing practices of black women in Macon County and the surrounding areas. Their focus was on increasing the skills of traditional midwives, improving the quality of pre- and post-natal care of childbearing women, and on decreasing the maternal and infant mortality rates of Alabama. In response to a 1918 Alabama State Law that required all midwives to pass an elementary examination and to register with the State Board of Health, Tuskegee University's John A. Andrew Hospital organized a training program for the midwives of Macon County. The purpose of the program was to help the midwives prepare for and pass the examination and to

³¹⁷ Catherine Corley, "Report of Nurses Activities, Macon County," October 1932 (ADAH, SG10367, Bureau of Maternal and Child Health Administration Files).

improve the quality of their work. The course ran for four weeks and covered many of the basic aspects of midwife work. “Whole periods were devoted to showing them how to wash their hands and care for the utensils in connection with their practice.”³¹⁸ The midwives were given lectures by the Memorial Hospital staff and were assigned, in groups, to nurses who they were to observe in the hospital setting. They learned how to prepare food for the mother and make beds and give baths, as well as some rudimentary procedures such as cutting and caring for the umbilical cord.

The midwives of Macon County were eager to learn as much as they could and were not intimidated by the hospital staff and setting. The nurses of Tuskegee noted, “It was interesting to see these women, some in their seventies, many of whom had never attended school a day in their lives, coming back and forth daily for their instruction. They were very enthusiastic over the work given them.”³¹⁹ The majority of women who participated in the institutes went on to register with the state board of health and receive a certificate to practice in the state. While childbearing women continued to be reluctant to approach the hospital, the midwives of Macon County embraced the Tuskegee programs. This fact speaks to the social identity of the midwives who participated in this program. They were not intimidated by the hospital setting because they identified as health-care workers themselves, despite the opinions of the majority of medical professionals. Health-care work was not considered by them to be the sole domain of middle-class professionals. A strong tradition of healing work arose from within Southern black rural culture, and midwives did not see a contradiction between their practices of folk healing and those of modern medicine. During the time of the Tuskegee Institutes, many midwives were

³¹⁸ John A. Kennedy, MD, “Service of a Negro Hospital” (Tuskegee University Archives, Tuskegee, AL [hereinafter TUA], Records of the School of Nursing).

³¹⁹ Ibid.

working in apprentice-like relationships with white physicians who openly shared information with them. Because of this relationship, traditional midwives did not have the sense that they were barred by their class, race, or gender from the world of modern medicine. They were the exception. The people in their communities felt a strong aversion to the world of professional medicine, and midwives were their only safe link to that world. They represented a spirit-based approach to healing that was a comfort to childbearing women. Childbearing women were more likely to accept new techniques and approaches to childbirth if they were delivered by a lay midwife.

Tuskegee University was involved in an array of services that had an impact on the culture of childbirth in Macon County. During the 1930s, Tuskegee University and the staff of the John A. Andrew Hospital organized a program that was intended to deliver health services to the surrounding population. It was called the Tuskegee Movable School. One of the primary focuses of the program was maternal and infant mortality. Supervising midwives and seeing prenatal patients were often the primary tasks of public health nurses. In her 1934 report to the Tuskegee Movable School a nurse wrote that the county physician had instructed her to give most of her time to “midwives and tuberculosis.”³²⁰ These two health issues were particularly suited for the Public Health Nurse, as they required hands on work in the rural communities and access to the homes and lifestyles of the community. The rural midwives of Alabama seemed comfortable sharing with the nurse the conditions they worked under.

The Tuskegee nurses assigned to the Movable School were directed to contact as many midwives and prenatal patients as they could in an effort to spread health information and teach

³²⁰ J.L. Dent, “Narrative Report of J.L. Dent, R.N. Movable School Nurse,” March 1935 (ADAH, Box SG7065, Files of the State Health Officer, Tuskegee Institute).

rudimentary skills. In addition, one of the assigned nurses conducted a weekly prenatal clinic at the institute hospital. Prenatal patients from the surrounding areas were invited to come to the clinic to receive prenatal information and testing. The nurse was often assisted by one of the hospital physicians. In 1935, the nurse recorded the following: “Dr. Griffin was assisted by the Movable School Nurse in the prenatal clinic on March 27th. There were ten patients in attendance. One thing that interested the Movable School Nurse was that two of the patients had engaged their midwives and encouraged them to attend the clinic with them.”³²¹ It seems to have surprised the nurse that midwives were willing to attend the clinic. Midwives, however, had a history of being open to receiving medical information and any type of health outreach services that could benefit their practices. It is likely that these midwives would have been familiar with the history of Tuskegee training programs initiated in 1918. Most midwives responded favorably to education and training programs, as well as group gatherings and organization. They entered participated in training programs from the 1920s through the thirties and forties.

The Movable School nurse, through her interviews with midwives and mothers living in remote areas of Alabama, was able to get a sense of what the experience of birth was like for many African-American women. Traditional midwives living in remote areas of the South had less contact with health professionals and relied solely on their own experiences and resources during a birth. Many women, especially midwives, had unassisted births. The Tuskegee Movable School nurse contacted a woman in 1935 who was both a midwife and a postnatal patient:

³²¹ Ibid.

Mrs. Emma Kidd, a postnatal patient was visited, [and] this patient is a midwife. When the baby came she said that she waited on herself; and out of seven children she has always been alone. She reported that she cut the cord herself, in fact she did everything. She made out the birth certificate and signed her sister-in-law's name to it.³²²

This woman may not have had the option of having a doctor present at any of her births. She told the nurse that she had been seen by a physician for a prenatal examination but was unable to have one present during the birth because she claimed that “no one was home to go for the doctor.”³²³ She may have been able to engage a fellow midwife or neighboring women to be with her. Perhaps she chose to be alone. There is no indication from her testimony that she viewed unassisted birth, as it happened in her case, to be a negative experience. She had enough experience as a midwife and a mother to feel that she could attend herself in a manner that was not considered by her to be unusual or dangerous. Midwives such as Emma Kidd were confident in their ability to handle the birth experience, whether their own or another's, by themselves.

The Tuskegee Movable School nurse found many midwives practicing who were elderly and in some cases ill or handicapped. These women found ways to compensate for their disabilities. A midwife in Camden County Alabama, interviewed by the nurse, was found to be very old and had lost sight in one of her eyes and could see very little out of the other eye. This woman was able to continue her practice through the help of her children who did her reading and writing for her, and a younger woman who she brought with her to help during deliveries.³²⁴ In 1945, a midwife from Talladega County, Alabama admitted to a nurse in her county that she had broken her wrist but had continued her practice with “the help of others.” Despite her condition she was

³²² *Ibid.*, January 1935.

³²³ *Ibid.*

³²⁴ *Ibid.*, May 1934.

able to present a complete and sterile set of materials to the nurse for inspection and maintained her permit to practice.³²⁵ In 1949, another Talladega midwife, Rosie Young, halted her practice due to poor health. When the nurse arrived at her home for an inspection she found that her equipment was “not together.” She noted that “as of today Rosie isn’t practicing any more until her health is better.”³²⁶ Four months later the nurse found her practicing again. Rosie told the nurse that she “has to go when they come for her.” Several weeks later she arrived at the health department office for a physical examination and a new permit. Later the same year she died of cancer.³²⁷

Several African-American midwives in this county felt that it was their responsibility to attend the childbearing women who were not able to acquire the services of a physician. Despite the increasing role of medical professionals in the childbearing experience, it was midwives who attended most deliveries. Although it was more likely that their patients would have been seen by a doctor or nurse for at least one prenatal examination in the 1930s and 1940s than in past decades, responsibility for the birth event remained on the shoulders of the lay midwife. In summary, it was very common for a midwife to continue an active practice despite a physical handicap, sickness, or old age. Midwives realized, as did health officials, that there was no replacement for their services. Moreover, in the traditional system, being a midwife was not a personal choice, but rather a spiritual calling. Rosie Young had begun her practice when she was nineteen years old. She received training from a traditional midwife and practiced on her own for many years before she came under the health department regulations. She accepted the rules

³²⁵ “Eliza Grace,” 1945 (TCMDH, ADAH).

³²⁶ “Rosie Young” (TCMDH, ADAH).

³²⁷ “Rosie Young” (TCMDH, ADAH).

of the health department, but maintained a traditional philosophy of the role of the midwife. Thus, despite her poor health she felt that she could not deny a woman who called her to a delivery. If traditional midwives did not respond to such calls, they believed that they were going against God's wishes and harm would come to them.

Midwives working during the Depression felt an increased level of responsibility to serve the women of the South. They knew that their patients had no other options for health care. They were barred from white hospitals due to racial segregation and they were uncomfortable in black hospitals due to class and culture barriers. They were unable to afford the services of a physician, and it seems clear that the majority of childbearing women preferred the services of the midwife over those of the physician.

African-American midwives who were not closely supervised during the Depression were able to maintain more of the birthing practices that childbearing women were familiar with and comforted by. Nurses found midwives in Clarke County, Alabama who continued with traditional practices such as the use of herbal teas. The midwives in this county reported that they regularly used "mistletoe, black pepper and ginger teas; [and] camphor, whiskey, castor oil and quinine to hasten labor."³²⁸ The practices associated with childbirth had been relatively unchanged by modern medicine. The midwives of this county had had sporadic contact with health officers, but were not under any type of regular supervision or training program. They appeared willing to disclose certain information to the nurse about their practices, but the physical experience of birth remained closely guarded. Midwives were reluctant to allow a medical professional to witness a birth. Nurses frequently reported the difficulty they experienced when they attempted to witness a birth. The Movable School nurse reported that she

³²⁸ Dent, "Narrative Report of J.L. Dent," January 1935.

had wanted to witness a birth on one of her visits to Clarke County, but was unable to because of the condition of the roads. It seems that the midwives in that area and others were unwilling to help facilitate nurses' visits to a birth. A Health Department nurse in Alabama recorded the following:

Considerable difficulty has been experienced in recent years in arranging for the supervision or at least observation of a delivery by midwives under permit. Difficulty has also been experienced in arrangement for the new midwives to observe deliveries under conditions in which the practices used are those taught by the health department. In spite of the fact that many of the midwives now under permit have been under health department supervision for the past ten years, it is the opinion of the nursing staff that they could not be trusted to conduct a delivery which would be a satisfactory demonstration of the accepted methods.³²⁹

Midwives in this area found ways to make it difficult for the nurse to observe them during a birth. They had not formed an intimate or even very cordial relationship with the nurse, which would have made them more comfortable sharing their birth practices with her. Unlike some of the midwives in Talladega County who were growing more comfortable with the presence of the nurse and the interference of the health department, these women who had been practicing in isolation for longer, were more resistant to forming such a relationship.

Some midwives may have wanted more health department intervention than they had, and others showed appreciation for the educational opportunities they received. Midwives working in Talladega and the immediate area surrounding Tuskegee University, who experienced heavier surveillance from public health nurses, were more likely to be observed during a birth, especially in the 1940s. Midwives in these areas had a closer relationship to modern medicine and some worked in partnership with health officials. Toward the end of this time period, some welcomed

³²⁹ Graham and Dix, "Appraisal of Health Services in Lee County, AL."

nurses into their birth rooms. There was large gap between the type of experience and work performed by a traditional midwife living in a remote area of the South during the Depression, and one who lived closer to an active health department in the mid to late 1940s. Within a decade many midwives were working in a vastly different way than in previous years. Some continued to resist health department ways and some mothers preferred their services. Meanwhile, the number of midwives who began to break away from the traditional way of practicing during this time period was growing, thus marking this time period as one of transitions.

The record of Vina Dates, a lay midwife who practiced in Talladega County, Alabama during the 1930's and 1940's, shows discrepancies between the discourses of the state bureau of health and the actual practices of nurses and doctors involved in midwife reform work. Bureau officials had stated their intention to eliminate midwives who were unfit for practice. In brief, midwives who did not closely follow health department regulations would not be granted permits to practice in the state. Vina was clearly resistant to such regulations, yet she was allowed to continue her practice, even after the death of a baby in her care.

Like most active midwives in the South at this time, Vina identified herself as a midwife and an agricultural laborer who had received training from various sources. In her initial interview conducted by the Alabama public health nurse, Vina said she had been trained in midwifery by a doctor, a midwife, and the public health department. She was in her early forties when the survey was taken, and she claimed that she had been practicing midwifery for seven years. When a nurse arrived to inspect her home and equipment in 1938, she recorded that the condition of her home was "fair," but Vina was "dirty" and had "very little equipment to show me." Vina asked not to be judged by the nurse for this visit, and promised to deliver for inspection her

midwife bag and a complete set of equipment to the next meeting. When she delivered these materials, the nurse recorded that they were in “much better condition,” and Vina was set to practice. Vina, however, did not attend meetings regularly after that; when she did attend, she often forgot to deliver her bag for inspection and her record book was incomplete. During a home inspection in 1946, the nurse found two holes in her midwife gown, described the lining of her bag as dirty, and reported that her equipment was not in the proper place and her bedside record book was not in her equipment bag. Despite her spotty record, Vina continued to practice midwifery in Talladega.³³⁰

The following year the nurse went to Vina’s home for another inspection and found her out on a case. The nurse was able to witness the birth. The nurse recorded that Vina used “no hot water, didn’t sterilize scissors, no cap and gown. Didn’t dress cord until she bathed the baby and started putting clothes on.” She also noted that Vina was “very dirty herself.” Following this incident, the nurse attempted to take her permit away, but Vina claimed she had left it in Kentucky and possibly lost it. Vina attended an office meeting soon after and tried to ensure the nurses that she would do better, but they revoked her permit for three months. After the three months passed, they went to her home and found her equipment and bag in perfect order, so they reinstated her permit to practice. Eight months later, she attended a woman who delivered twins, a boy and a girl. After she had left, the father contacted Vina to tell her that the boy was bleeding from the navel. Vina told the father that the cord was not tied tight enough and that he could retie it. He asked that she come back to the home and do it, which she did. The bleeding stopped for a while and then restarted. The baby boy died three days later. After this incident, the nurse persuaded the county doctor to permanently remove Vina’s permit. Four days later,

³³⁰ “Vina Dates” (TCMDH, ADAH).

Vina went to the health department to speak with the doctor. She convinced him to let her return to her practice if she promised to do better. She practiced for two more years until she lost her supplies in a house fire.³³¹

The example of Vina Dates highlights the differences in style between the nurses and the doctors working in this county. The nurses were more likely to attempt to revoke the permit of a midwife under their supervision. In this case, Vina went directly to the health department doctor to see about getting her permit reinstated. Perhaps her experience in the county led her to believe that the physician would be more lenient than the public health nurse.

A number of midwives in Talladega County working in the 1930s and 1940s, like Vina Dates, routinely ignored health department training and standards for practice. These women often skipped health department meetings and were described by health department staff as difficult to monitor. One of the most common infractions was not following official cleanliness techniques. Another common infraction among the women of this group was to perform internal examinations on women during labor, which was strictly forbidden by the local health department.

Ella Terrell was often guilty of both types of infractions, and yet had an active practice in Talladega County. Ella was relatively young--sixty-three in 1940--almost ten years younger than others who practiced in her county. She had been trained by another midwife and by the health department. During a home inspection in 1938, the local nurse found Ella working in her garden. Ella did not wash her hands or change her dress before showing the nurse her supplies. This was an indication to the nurse that she did not follow proper sterilization techniques in her

³³¹ Ibid.

practice. Her equipment was found by the nurse to be in “very poor condition.”³³² On another home inspection in 1939, her equipment was again checked by the nurse and she found the lining of her bag to be dirty and the bag itself incomplete. She reported, “towel absent, cap and mask dirty, nail stick absent, person and home dirty.”³³³ Ella apologized to the nurse for her equipment being in such a condition, but the condition of her materials did not change on subsequent visits. During a home inspection in 1947, the nurse found her equipment to be “very dingy.” In the leather bag she had some cord dressings that were unwrapped, as well as “two pairs of scissors, one pair of forceps, one brush, one orange stick, and a pencil.” The nurse instructed her to get the proper supplies but did not comment directly on the forceps until a home inspection over a month later when she “told her she couldn’t use the forceps and to take them out.” Later in 1947, the nurse inspected her bag again and found that her equipment was not “together” (i.e., equipment and supplies were incomplete or disorganized). On another visit her supplies were complete, but they were “dirty and dingy.” The midwife was finally reprimanded in 1949 and had her permit temporarily revoked for failing to contact a physician when a patient had difficulties and was in labor for nineteen hours. The husband had suggested that they call a doctor but Ella told him that she “didn’t need one.” The baby lived for two hours. When she came into the health department office in June of 1949, the nurse revoked her permit and told her not to deliver one of her prenatal patients, Annie Laura Welch. Less than an hour after she had left the office, the nurse discovered that Ella had gone home to get her midwife bag and had gone to deliver Welch’s baby with outdated permit in hand.³³⁴

³³² “Ella Terrell,” 1938–1940 (TCMDH, ADAH).

³³³ “Ella Terrell,” 1939 (TCMDH, ADAH).

³³⁴ “Ella Terrel,” 1950 (TCHDH, ADAH).

A few days before she her permit was revoked, the nurse was told by a patient of Ella's that Ella had performed a vaginal exam on her. The day after the delivery, the patient's temperature had risen to 102 degrees and the doctor suspected that this was caused by the exam. The patient's mother went to the health department several months later to confirm that Ella had performed a vaginal exam on her daughter. But it was not until five months later when Ella arrived at the health department office for an inspection of her bag and equipment, which was found to be "dingy and incomplete," that the nurse revoked her permit "based on a review of her past record."³³⁵

Ella's record indicates the complexities of behavior exhibited by certain African American midwives during this period of transition. In her initial interview she claimed to have been trained by a traditional midwife, yet she carried a health department permit to practice and received training by the local public health nurse. She carried some supplies that were intended only for use by a physician, and she did not keep her other supplies in proper order. She did not maintain the cleanliness techniques taught by the nurses. She had worked independently for many years before health department intervention. Her years of independent operation may have been a critical factor in determining her methods of practice. Ella willingly submitted herself for inspection by the nurse, however she chose not to abide by the regulations imposed by the health department. Her methods of practice were formed independent of the health department, yet she remained under its care. She had a foothold in the traditions of independent midwives, and a foot in the world of modern medicine, and seemed to satisfy the regulations of neither. She was unsuccessful in her attempts to care for some patients, perhaps because of her inability to negotiate her place in both the traditional and modern worlds of medicine.

³³⁵ Ibid.

Several younger and more educated women had a tenuous and conflicting relationship to the health department, yet they maintained a steady practice among childbearing women in their communities. Mary Jane Prather, a midwife in the 1940s in Talladega County. She was unusual in that she was fairly young--fifty-two in 1940--and well educated. She was trained as a nurse many years before, and in the late 1930s began her training as a midwife. According to the public doctrine of the health department, she should have been a model midwife. She was young, literate, and had received some professional training. However, she was one of the most rebellious midwives under supervision in Talladega County.

In 1943, the county health department nurse records that Mary Prather “will not attend meetings.”³³⁶ A few years previously, the nurse surmised that “this midwife is an R.N. and seems to resent having any instruction. She has only one bag and refuses to show it.” The nurse advised her to get the proper supplies and begin attending meetings. On another investigation, the nurse notes that Mary Prather will not attend meetings, yet “she delivers more babies than the average midwife.” The nurse managed to observe her on a case soon after this observation, and arrived just after the baby had been delivered. Mary claimed that she had not been able to administer prenatal care to the woman because she was called by the husband only when labor had commenced. The nurse observed that Mary was clad in a “soiled dress, no cap, mask, no gown.” Mary, said the nurse, “had to be reminded when to wash hands. Cords were tied and dressed with unsterile ties and greased rags.” More disturbing to the nurse was that Mary seemed unsure about how to inspect the afterbirth, and was “reluctant to learn” how to do so. The mattress on which the laboring woman lay had a quilt over it and a few sheets of paper were placed under the patient, but these were insufficient to keep the mattress dry. Mary Prather had

³³⁶ “Mary Jane Prather” (TCMDH, ADAH).

ignored the protocol of preparing thick mattress “pads” out of newspaper to keep the bed dry during labor. Despite the frustrations of the county nurse, Mary was able to continue her practice, and for several years she continued to ignore meetings and health department procedures.³³⁷

In 1943, Mary was advised to cease practicing midwifery, and to tell any woman who attempted to engage her that she would be unable to do so. Mary ignored the warnings of the health department; in 1949 the nurse recorded that she “continues to practice midwifery without a permit.”³³⁸ Dr. Sims brought the matter to the attention of county health board members, who then responded that Mary was “as good as any of the other midwives,” and that they “saw no need for action...”³³⁹

Mary Jane Prather was an unusual type of midwife for Talladega County and for the rural South at this time. She was fairly young, not married, and seemingly without children. She had received training as a nurse many years before deciding to begin a midwife practice. She resisted midwife regulation on many levels, but did not appear to practice any traditional techniques or to have received training from a traditional midwife.

The fact that a younger, registered nurse practicing midwifery would have been active in this county indicates a shift in preferences among childbearing women. By the 1940s, childbearing women would have been more familiar with medical professionals and more likely to trust someone who had received formal medical training. Mary Prather’s unwillingness to follow the proper techniques as mandated by the health department did not have an impact on her practice among the childbearing women of her community. Her services continued to be requested even

³³⁷ Ibid.

³³⁸ Ibid.

³³⁹ Ibid.

after she had her permit revoked. Mary and other midwives in this county continued to practice without permits throughout the 1940s. It is unclear from the sources available what determined the activity or inactivity of certain individual practitioners. As stated, it was recorded that Mary Prather delivered more babies than the average midwife in her county. This could have been because of qualities that were deemed desirable, or due to her relative proximity to a larger pool of childbearing women. It seems from the sources investigated in this study that there were some limited options even through the 1930's and 1940's for childbearing women. They may not have been able to engage the services of a physician due to the expense, the low numbers of physicians who delivered women at home, and the inability or unwillingness to travel to a hospital. However, there was an adequate number of practicing midwives, as well as the option of engaging a female relative, neighbor, or even laboring alone. A certain number of childbearing women, above the average, requested the services of Mary Prather, despite her spotty record with the department of health. It is also quite possible that the women under her care were unaware of her formal record or even that she had had her permit revoked. Whatever the case, she is representative of a complex, transitional figure that became more visible during the time period of the late 1930's and 1940's.

Sallie Hall was similar to Mary Jane Prather in that she was the same age and had trouble maintaining aseptic practices taught by the health department. In 1940, her bag was inspected by the nurse and the contents were found to be unclean and not in the proper order. The outer lining of her bag had "papers and rags in it. Her silver nitrate was old and her cord dressings were unsterile ... and her scissors were stained with blood." Despite her own regular infractions, she went to the health department office that same year to report two midwives who were practicing without a permit.

It was common for midwives in this transitional period to have had diversified backgrounds and various types of training. The majority had practiced upward of ten years by the time they were interviewed in the mid-1930s, and had experienced some level of autonomy before the health department interventions. Eliza Grace, who had an active practice during the late 1930s and 1940s, had not received formal medical training, but did claim to have been taught by a doctor, as well as by the health department and a traditional midwife.³⁴⁰ Alder Routledge, who began her practice in 1942 and claimed to have not yet attended a delivery at the time, informed the nurse that she knew how to stop a woman from hemorrhaging.³⁴¹ This is an indication of knowledge in the use of teas. As described in previous chapters, teas were often used by traditional midwives to stop or prevent bleeding. It is tempting to speculate that Alder Routledge knew how to stop bleeding because of exposure to women in her community who had such knowledge.

Midwives in this time period exerted different levels of willingness to disclose information to health-care professionals. Rosa Little, active in Talladega County in the late 1930s and 1940s, began her practice in her early fifties, and stated for the record that she had been taught only by the health unit, not by a traditional midwife. Rosa Little was not openly resistant to health department practices: her bag and equipment were usually in good condition, she did have to be reminded to attend midwife meetings regularly, but was not as defiant as many others who were active in her county. However, in 1940, the nurse advised her to “discontinue the use of teas and report all miscarriages that the Dr. leaves for her to care for.”³⁴² This record indicates that despite what she had told her interviewer, she had received some training or at least was

³⁴⁰ “Eliza Grace” (TCMDH, ADAH).

³⁴¹ “Alder Routledge” (TCMDH, ADAH).

³⁴² “Rosa Little” (TCMDH, ADAH).

knowledgeable about traditional healing methods such as the use of teas. The midwives under supervision were ardently instructed to only attend women who were full term, and to report to a doctor if any complication should arise. Yet there is some indication from this record and others that midwives did attend miscarriages. Rosa Little had a mixed identity as a health-care provider. She identified herself as a health department-trained midwife, not a traditionally trained midwife. She was not overtly defiant of the health department, yet she demonstrated certain independent behaviors that were typical of a traditional midwife in a previous era.

Midwives such as Rosa who were not literate usually received help filling out birth certificates from other midwives during county meetings. Since Rosa did not regularly attend meetings, she may not have had a chance to get caught up with recording her births. Rosa was allowed to continue her practice despite her spotty record and her use of traditional healing methods because she was not openly or aggressively resistant to the nurses' instructions.

Midwives such as Rosa were the most common type in Talladega county. They maintained an appearance of compliance, and were not hostile toward the nurses in charge of midwife supervision. Yet they often avoided group meetings and inspections, and did not follow the proper procedures for their equipment and record keeping. Rosa is an example of a transitional figure. She embodied elements of the traditional midwife at the same time that she accepted state regulation programs.

Many midwives in this time period did follow health department procedures and willingly contacted a physician when a complication arose. In 1938, midwife Celia Jemison contacted a doctor at the appropriate time. She was on a case where the baby presented in a breech position. Celia called the physician, but he did not arrive in time to deliver. After the delivery, Celia visited the health department offices to report the case to the nurse. She told the nurse that the

baby had been breech and that she had called the doctor but he was too late. The nurse instructed her to have the woman come in to see the doctor for a pelvic examination after the birth. As of the late 1930s, many midwives were still left on their own to handle difficult and dangerous situations without the help of a health department official or medical professional, despite written and verbal statements of health department officials. This situation is a condition that carried over from the 1920s, and midwives were most likely well aware that they were on their own for the most part during labor. Midwives such as Rosa Little were reprimanded for not contacting a physician in the case of miscarriage or preterm delivery, yet when Celia Jemison did contact a physician at the appropriate time she did not receive the support she requested. During the 1930s and 1940s, health departments were in a state of transition as well. They attempted to uphold the standards of practice and care that they espoused, but were often unable to do so due to inadequate resources.

When Judy McElderry was asked about her training, she stated that she had worked with a doctor and the health department. She did not claim to have been trained by a midwife, yet she stated that she had been practicing for thirty years, and she was in her mid forties when the survey was taken. This indicates that she had begun to practice midwifery in her teens, and that she most likely had received some previous training. The nurse noted that Judy was able to read and write very well. Given her age and her literacy, Judy would have been considered a very desirable prospective midwife. Despite that fact that she had been practicing independently for many years, she would have been considered very trainable by health department standards. In 1938, the nurse made a visit to her home and found it to be “clean and neat.” In addition, Judy was “clean and she was very happy to have the nurse visit her.” The nurse found her equipment to be in “perfect” condition. In 1939 on another home inspection, the nurse found her “outfits

equipped” and her “home clean.” Judy washed her hands before she showed the nurse her equipment for a birth.³⁴³ This was a strong indication to the nurse that she was following the cleanliness techniques taught by the health department.

Judy was not openly resistant to health department regulations. Perhaps the length of time she had been practicing before the initiation of midwife regulation gave her confidence in her practice such that she was not resentful of health department intervention. In addition, her training with a doctor may have also prepared her for a relationship with the local health department.

Age was not a steady indicator for the level of resentment a midwife would have towards the impositions and regulations of the health department staff. Some who were compliant were quite young, and some were older. Margaret Burt was different from Judy McElderry in that she was much older, about seventy-two when she was first interviewed by the nurse. She had been practicing midwifery for forty years. Margaret would not have been considered a good candidate for the midwife regulation program and in some counties may have been denied a permit. When a nurse arrived at her home for an inspection in the late 1930s, Margaret was out in the field working. She did not change her dress or wash her hands before showing the nurse her equipment, but her home was described as “neat and clean” by the nurse. She thanked the nurse for her visit. On each home visit, the nurse found Margaret always busy, either quilting or working in the field, but her home was always clean and she appeared to be pleased with the visit. Margaret often led the midwife song and prayer during health department meetings. She did not give any signs of being resistant to the health department regulations.

³⁴³ “Judy McElderry” (TCMDH, ADAH).

Despite her age and length of practice, Margaret was more compliant, in terms that were visible to the health department, than some of the younger midwives in her county. She reported that she had been trained by both a local physician and the health department, but had most likely--due to her age and length of time practicing--received training from a traditional midwife as well. Margaret, and other midwives like her, welcomed the visits of the nurses and did not feel threatened by them because of the length of their experience. Given the conditions of her life, she was elderly and lived in a remote area, she may have been happy for the company and for the information provided by the health department. By the late 1930s, Margaret was on average attending twelve cases a year. She was not one of the most active midwives in the county, but she had a steady practice. The fact that she offered the names of her prenatal patients to be visited by the nurse and that she led the song and prayer during health department meetings indicates that she was neutral to, and perhaps appreciative of the feedback she received from the nurses. Her positive spirit was further demonstrated in 1940 when she attended the annual midwife picnic despite the fact that she had a patient she was expecting to deliver at any moment. She had left her bag and equipment at the patient's house so that she could be ready for the delivery after her health department obligations were completed.³⁴⁴ This indicates a strong affiliation with this type of organized activity, which several others appeared to shun.

Individual midwives responded to the health department regulations and training differently. By the late 1930s and 1940s, it was more difficult for midwives to maintain a practice independent of respective state health departments. It was likely that midwives would have been observed by a medical professional during a procedure, in a training session, or during a midwife club meeting. This is a significant shift: The birthing rooms of childbearing women were no

³⁴⁴ "Margaret Burt" (TCMDH, ADAH).

longer kept strictly behind the veil. Hiding transgressions became more difficult, and some simply chose to openly defy the health department. Others, such as Eliza Grace, seemed to more or less embrace health department codes and work in a partnership type of relationship with the nurses in their county.

When a nurse arrived at Eliza's home in 1938 for an inspection she found her "home clean, midwife clean--found sewing." According to the nurse, Eliza appreciated her visit. As evidence of this, the midwife requested an additional home visit later the same year. She missed several meetings in subsequent years because she was attending clients, but she did allow the nurse to observe her in the birthing room of Henrietta Charman. The nurse reported that Eliza's supplies were "clean and in order" and that the "health department instructions were followed."³⁴⁵

Eliza Grace seemed to embrace the spirit of the health department codes of conduct. She also consistently had patients among women in her community.³⁴⁶ Her record of service indicates that during the 1930s and 1940s in Alabama, it was possible for midwives who had knowledge gained from traditional sources as well as health department training to meet the expectations of health department officials as well as the childbearing women in their communities.

In the 1930s, a new figure began to emerge: a midwife trained only by the health department. Rebecca McGee is one of the first examples of a midwife practicing in Talladega County who began her practice only after receiving a permit from the health department. In contrast to almost all other midwives in Talladega, she did not have training from a midwife or a doctor before she became a health department-certified midwife. Most of the other women in the records for this county had been practicing for ten to thirty years before receiving an official

³⁴⁵ "Eliza Grace" (TCMDH, ADAH).

³⁴⁶ Ibid.

permit. Rebecca was the exception in this and other ways, but she was indicative of the changes under way at this time.

Rebecca worked very closely with the nurses involved in midwife regulation. She was not always perfect in her practice, but she had a style of practice that appeared to be in accord with the health department. During a home inspection in 1938, the nurse found her home clean but “did not find bag in good condition.” This fact is offset by the nurse’s feeling that “Rebecca always welcomes me in her home.”³⁴⁷ After a home inspection in 1930, the nurse reported that Rebecca’s home was clean and that Rebecca told her that she was “trying hard to follow all orders.”³⁴⁸ Later that year, Rebecca spent the day visiting with the nurse and reported on another midwife who was “taking care of miscarriages.” In 1941, she was elected president of the midwife group, and in 1942, she named another midwife who had attended a case of miscarriage.

Unlike many of her counterparts, Rebecca reported to the nurse her prenatal patients and on occasion the nurse accompanied her on prenatal visits. Rebecca voluntarily spent more time with health department nurses, and not only maintained an appearance of compliance but in reality worked in a partnership type of relationship with the health department. For instance, on November 6, 1939, the nurse noted that Rebecca “spent day visiting with me,” and that she “reported Josie Sawyer as taking care of miscarriages.”³⁴⁹ Rebecca reported Josie Sawyer twice for attending a miscarriage, an act that was very unusual for a lay midwife at this time, and shows that her allegiances were more with the health department than other midwives in the county. It was highly unusual for a midwife to report another midwife’s infraction. Her record

³⁴⁷ “Rebecca McGee” (TCMDH, ADAH).

³⁴⁸ Ibid.

³⁴⁹ Ibid.

also has more frequent mention of contacting a physician than most others. On August 2, 1937, Rebecca was called to a case because her patient's water had broken. When she arrived, she realized that although her water had broken, the patient was not having labor pains. The nurse noted that Rebecca "did not understand case," and so contacted the doctor. The doctor was unable to save the baby who was born the following night but lived for only ten minutes. Two days later, on August 4, Rebecca was called to another challenging case. The baby was delivered stillborn with the cord wrapped around its neck. In this instance, Rebecca called the doctor only after the baby was born. Rebecca had as many stillbirths as other midwives and more than some. She seemed to contact the doctor more frequently, and the doctor responded to her call. Other midwives had trouble getting doctors to respond to their calls. Rebecca had a closer relationship with the health department in Talladega, and because of this the doctor may have been more likely to assist one of her patients. Since Rebecca had no prior midwife experience it is also likely that she was less confident in her ability to handle challenging cases, and the doctors in her area may have known that she was likely to need more help. Midwives who were familiar with traditional practices and who had received some training from an elder midwife were taught ways to deal with complications; these ways were not sanctioned by the health department but many women continued to use them because they trusted them and they often had no alternative resources. Rebecca did not have access to these resources and so had no other choice but to contact the physician.

Rebecca was in complete agreement with the goals of the midwife regulation program, and was rewarded for this by being elected president of her midwife group. The image that Rebecca maintained throughout the 1930s and 1940s of working closely with health professionals and of being a more modern type of midwife did not appear to boost her reputation with the

childbearing women in her county. Midwives who were openly resistant and those who were subtle in their transgressions were just as busy, and some more so, than Rebecca, despite her position of leadership within the health department. Midwives who were well regarded by the health department staff were not necessarily more often engaged by women in their communities. The viewpoints of childbearing women of the South were independent to those of the health-care professionals that worked among them in terms of birthing choices. This had been the case since the end of enslavement and it remained so in the two decades discussed here. Childbearing women did not necessarily reject a midwife if she upheld the standards of practice set forth by the health department, but this was not the deciding criteria. They maintained their own system for choosing a birth attendant; at this time in history, they had not equated professionalization of practice with better health or safety for themselves and their babies.

By 1940, most counties of Alabama had accepted the idea that they needed a certain number of licensed midwives in each county to cover childbirth assistance demands. This was true for areas such as Macon County that did have a black hospital, as well as more remote counties where there were very few physicians available for delivery services. The number of active midwives practicing in Macon County, Alabama, was reduced from 125 to 50 in a two-year period. The decrease in the number of midwives, however, did not lead to a reduction in the number of midwife-assisted births. The fifty remaining midwives in Macon County were very busy despite the presence of a well-established black hospital. In 1939, in Bullock County, there were 586 live births recorded. Out of the 586, a total of 91.8 percent were delivered by midwives, and 8.2 percent were delivered by physicians. None of the physician-assisted deliveries were performed in a hospital. Physicians delivered nine black women, and midwives delivered 17 white women. It was noted by the public health nurse in this county that “the

midwives have been accepted as, and actually are, a very necessary factor in the delivery service in Bullock County. They play an important role in delivering practically all the negro babies and as indicated, a few of the white babies.”³⁵⁰ In Chambers County, a similar sentiment was expressed by the public health nurse, who stated, “in all probability the physicians of the County could and would deliver all white mothers but that for the negro group the midwives are a necessity.”³⁵¹ Although the actual numbers of practicing African-American midwives had been reduced, the role that they played in the childbirth experience in the South had not significantly changed. In the 1930s and 1940s, change was under way, but the lay midwife had not yet been replaced, despite some limited efforts to do so.

In 1939, Tuskegee began to explore a new approach to the midwife issue that was geared toward increasing the number of professionally trained African-American women who were involved in the birth experience. Two nurses from the Tuskegee Nursing School were sent to the Maternity Center Association in New York City to receive training in midwifery.³⁵² After finishing the program they returned to Alabama and were assigned to two areas in Macon County. The nurses were to work with an obstetrician, a resident of the John A. Andrew Hospital, to provide medical services to the local population. The nurse-midwives were expected to oversee the work of lay midwives, supervise births, and provide general health information to the local population. The intent of the program was “to provide a rural nurse-

³⁵⁰ Ibid.

³⁵¹ A.H. Graham and Mary Lorenz, “Appraisal of Health Services in Macon County, Alabama for the Year 1939,” May 1940 (ADAH, Box SG4437, (State Government Records, Records of the State Department of Health).

³⁵² Litoff, *American Midwives, 1860 to the Present*. In her chapter on nurse-midwives, Litoff describes the work of the Maternity Center Association, which was primarily a training center for white nurses to become nurse-midwives, as “truly commendable.” She notes that graduates of the Association went to Alabama, Maryland, and other Southern states to assist in the training of traditional African-American midwives (p. 127).

midwife delivery service in an area predominately colored, and to expand to this area prenatal medical service through the obstetrician employed.”³⁵³ The nurse-midwives were expected to do most of the prenatal work and regulate the lay midwives, but were not expected to actually deliver the majority of women:

It was not intended that the nurse-midwives take over the whole delivery duty in the selected area, but rather it was hoped that they would do the bulk of the work, and to carefully supervise and aid in regulating the practice of the midwives in that zone.³⁵⁴

This was the first moment in the South that the insertion of a professionally trained nurse-midwife was the focus of a midwife reform program. It was a logical step toward professionalization, yet it had a hard time gaining momentum.

The Tuskegee-trained nurse-midwife had a unique position in the childbirth experience. Unlike the public health nurse, she was a trained midwife and therefore had a more intimate relationship with the childbirth experience. Her sole task was to oversee the birth practices of women in her assigned area. Unlike public health nurses working in midwife regulation, the nurse-midwives had greater access to the birth rooms of the rural South. A small number of deliveries were actually performed solely by the nurse-midwives, and a “very large number were personally supervised and done by them,” with the traditional midwife present.³⁵⁵ Because there were not enough of them to cover the needs of the population, the nurse-midwife was not considered a replacement for the lay midwife. The intention of the program was that she would

³⁵³ Graham and Lorenz, “Appraisal of Health Services in Macon County.”

³⁵⁴ Ibid.

³⁵⁵ Ibid.

be able to elevate the level of care given rural African-American women through her presence in the community and her work with the other active midwives in her area.

A few years after the nurse-midwife delivery service was established, Tuskegee University, the Rosenwald Fund, and the National Children's Bureau agreed to fund a school for nurse-midwifery that was to be housed at the John A. Andrew Hospital. The training program was intended to provide hospital and field experience as well as a course of instruction to qualified nurses to be certified nurse-midwives. The Tuskegee program was an alternative to sending nurses to New York to be trained at the Maternity Center Association. The stated purpose of the school was to improve the maternal and infant mortality rates of the rural poor, particularly the black poor.

The bulletin for the Tuskegee School for Nurse Midwifery reflected many of the same biases against the traditional midwife that had been common in mainstream medical journals for decades. According to a bulletin in 1941,

Since so many of the sharecroppers who cannot afford medical care or hospitalization are left to the dubious care of the ignorant granny midwives, it was hoped that the maternal deaths could be reduced by providing better care during confinement. The most practical plan seemed to be to train nurses to be midwives.³⁵⁶

Despite the fact that Tuskegee University had been involved in midwife education programs since 1918, their public discourse included condemnation of the rural midwives of Alabama. The nurse-midwives were juxtaposed against traditional midwives and described as a "safer" alternative for mothers. In this way, Tuskegee program spokespersons echoed the image of the lay midwife that was common among mainstream medical institutions.

³⁵⁶ Bulletin, Tuskegee School of Midwifery for Colored Nurses, 1941 (TUA, Records of the School of Nursing).

The program, which ran for only four years, had a lasting impact on the experience of childbirth and the history of midwifery among Southern black communities. The nurses who participated in the program came from Alabama as well as other Southern states; they returned to their home states after completion of the program and delivered medical services for many years to the population of women and midwives in their area of practice.

Tuskegee University was attempting to improve the health of childbearing women, but they were also concerned with the negative image of the “granny” midwife. The Tuskegee program for nurses reflected the changing position of African-American women in health care and the changing perceptions of childbirth among African-American health professionals. In this time period, African-American doctors and nurses intensified their own push for equality in mainstream medical organizations. Therefore, they were concerned with divorcing themselves from the folk practitioner who was viewed as a nonprofessional and a medical risk to African-American families. They set out to transform the image of the midwife from that of the folksy unclean “granny” to that of a starched, white-uniformed nurse-like professional. The photographs used in the Tuskegee Bulletin promoted the idea that a woman who was professional looking and resembled a middle-class health-care worker was a safer choice for mother and baby. This was an attempt to transition childbearing women away from the idea that the traditional attendant was equal to a professionally trained nurse.

Alabama state and county health departments and the staff of Tuskegee’s Andrew Hospital had overlapping but somewhat different goals for the transformation of childbirth practices among Southern black communities. The health departments were primarily concerned with monitoring the work of lay midwives. They organized the certification process and group meetings and provided some basic supplies. Tuskegee-sponsored programs had a stronger

emphasis on education and training. From 1918 through the 1940s, the school held training programs and prenatal clinics, as well as the delivery of health information through the Movable School. The Tuskegee School for Nurse-Midwifery was the culmination of a series of programs sponsored by the Institute. Although short-lived, the training program was significant in that it marked a turning point in the history of childbirth in the Southern black population. African-American midwives and medical professionals began to understand that they would have to work together in order to provide the best possible care for rural childbearing women and infants, which they felt should be in the hands of medically trained professionals. The focus of both organizations was to strip from the lay midwife her independent status and the manifestations of folk religious belief systems in her practice. These two factors were considered the greatest threat to the health of mothers and babies.

African-American medical professionals seemed uncomfortable with the image of the “granny” midwife and the experience of traditional home birth. However, it was clear that there were not enough black physicians to cover community needs, and white doctors were unwilling to take on this population due to the social climate of racial segregation. Therefore, lay midwives continued to be referred to as a “necessary evil.” The nurse-midwife was considered by health officials to be the perfect compromise. The Tuskegee program ended before enough nurses could be trained to meet the needs of all poor childbearing women in the South. The traditional lay midwife continued to play an important role in the childbirth experience until the 1970s.

During the 1930s and 1940s, lay midwife practice varied depending on the proximity of a functioning health department, the background and training of the midwife, the length of time she had been practicing, and individual personality. Midwives who lived in more isolated areas

of the South were less likely to be under strict observation, and they appeared to be more willing to disclose to the nurses from Tuskegee details about their practices such as the use of traditional healing methods. However, they were less willing to have a nurse observe them during a birth. Those who lived in closer proximity to a functioning health department, such as in Talladega County, worked under the watchful eye of a health department nurse. It was more likely that they would be reprimanded for using traditional methods. Some were more likely to work in partnership types of relationships with a local nurse. They were more willing to allow a nurse to observe them during a delivery and to have their patients be seen by a physician for a prenatal examination. Others preferred to maintain a defiant independence to the interests of the health department.

During the 1930's and 1940's the options available to childbearing African American women of the South began to widen. There were midwives still practicing traditional methods in the South. There were also a number of transitional figures. These women had a variety of training and experiences. Some were trained by traditional midwives in an apprentice-like relationship, as they had been at the beginning of the twentieth century. Others took advantage of increased opportunities for training from the local health departments of their county and state. African-American women of the South seemed more willing during this time period to accept a midwife who had increased medical training and who was working closely with the local health department. They were more willing visit a physician, or a prenatal clinic during pregnancy, and may have begun to recognize the validity of professional medical intervention during the birth experience. However, they maintained an indifferent stance towards the maternity ward of John Andrew Hospital. Perhaps this was because they were unwilling to abandon all traditional practices delivered by midwives during the birth event. This is one of the reasons why the lay

midwife continued to have a significant impact on the experience of childbirth in the South through the 1940s, and would continue to do so until well past the first half of the century.

Chapter Five: Visual and Discursive Portrayals of Midwives

In medical journals of the mid-1920s, portrayals of African-American midwives that reflected the worst type of stereotyping and degradation were common. A 1926 article in the *Public Health Nurse* journal indicated that the practices of African-American midwives were the same or similar to those that had been used before Emancipation.

More often the customs and superstitions of the African Jungle were handed down among the plantation “darkies” and not infrequently the services of the midwife were extended to the household of the plantation owner without omitting any of the unwholesome customs and weird incantations practiced in the quarters.... The coming of freedom did not appreciably change this state of affairs.³⁵⁷

Along with this description of childbirth practices there was a photo that was meant to further portray an image of African-American midwifery. The accompanying photograph is of seven children lined up by height and age next to an elder African-American women who is slumped over in posture and wearing a plain cotton dress and hat. The woman is standing next to a pile of sticks and a wooden shack. She is intended to be a midwife, and presumably the woman who had delivered the children standing in front of her. She does not bear, however, any visible markers of being a midwife or being associated with health work. She does not carry, for example, a bag for supplies or wear a uniform. The caption of the photo reads: “Seven little brothers and sisters offered by one midwife as evidence that she ‘knows sump’n ‘bout chillens, bofe a-bearin’ of ‘em and a-kotchin’ of ‘em.”³⁵⁸ This journal article utilizes three common methods of portraying the African-American midwife: derogatory language, photography, and

³⁵⁷ Jessie Marriner, “Midwifery in Alabama,” *Public Health Nurse* 18, no. 3 (March 1926), 128.

³⁵⁸ Ibid.

the use of dialect language. These methods were used to portray midwives in a negative light to show how they behaved before the period of regulation, and then in a very different way to describe the benefits of midwife regulation programs and state intervention.

In the same article there is an additional photograph. In this photo there is a group of midwives who had received training by the health department. These women are sitting in rows and are wearing white apron dresses and white caps. Several of them are holding on their laps a black leather doctor's bag. The caption under this photograph reads: "A group of Midwives in Covington County—all of them have had some instruction and been issued 'permits' in the county."³⁵⁹ These women appear to be more orderly, as they are seated in rows, and are wearing and carrying several visual markers of midwife education: a white apron, and white cap, and the black leather doctor's bag.

This chapter will describe several examples of the ways in which the effects of midwife regulation programs were depicted through verbal and visual discourse. Health departments meant to spread the message that midwives had been transformed, and they were both responsible for and in control of that transformation. In actuality, midwives had been transformed. They had become, by the mid to late 1940s and early 1950s, a very different group in many ways. They were more likely to be involved in health work, for example, that spread much further than the delivery of babies. They were health activists in their communities. This chapter will also describe how midwives went beyond birth in this time period, while still acknowledging the original intentions of their work and their lives: to act in accordance with their original calling from God.

³⁵⁹ Ibid.

In an article published in *Public Health Nurse* in 1921, the very first year of midwife regulation, it is apparent that the use of dialect would be used to verify the need for the intervention of the state. A nurse, Miss Rhines, was described as being undaunted in her pursuit of the “old mammies.” She “selected a convenient grove and issued a summons to each midwife to meet her there on a certain day. The magic term, ‘gov’ment nuss,’ is a name to conjure with, and information concerning the new ‘gov’ment’ laws brought every one with fear and trembling to the trysting place.”³⁶⁰ Although the group was described as fearful at first, the article makes it clear that once they understood the purpose of the meetings, “they were coming, from the pure joy of meeting the nurse and sitting at the feet of this mentor who dispensed such an amazing wealth of knowledge.”³⁶¹ The use of dialect in this article is used to inform the reader of the cultural status of the women to receive instruction. It is intended to hint at their illiteracy, their rural culture, and the social distance between them and the nurse who was to provide instruction. It is in some cases subtle, but the repeated and persistent use of such dialect in contrast with descriptions of the proper type of midwife exemplifies some of the underlying themes of midwife regulation and its power to transform the image of midwifery and childbirth in the South.

Alongside the text of this article, there are several photographs that further emphasize the point of the necessity of regulation. There is included in the text a photo with the caption, “Regulation of Midwifery in Tampa, Florida.” The photo is of a group of women seated outside the office of the Tampa Health Center. There are three rows of midwives with one white woman, presumably a nurse by her appearance, sitting in the middle front. It resembles what we

³⁶⁰ Dodd, “An Open Air Class,” 290.

³⁶¹ Ibid.

would think of today as a class photo. The women are all wearing white aprons; a few are also wearing hats and white bonnets. There is one black woman at the back left in a white dress shirt and glasses. She may be another nurse. The midwives are recognizable as being under supervision because of the presence of several nurses, the way they are arranged in rows, and their apparel—while it is still informal in this time period, they are wearing the white aprons that were intended to provide protection to the mother. The apron was considered a sterile barrier between the clothing of the midwife and the woman she was to deliver. It was a visual symbol of their training.

It was common for medical health journals to focus on the importance of cleanliness among the midwives they trained. A description of a training program in Amite County, Mississippi, in 1941, stated the following:

We have 30 practicing midwives in this county, all of them colored.... The midwife's equipment must be clean and her bag must pass inspection at any time the health nurse asks to look it over. Her home and surroundings must be kept clean, because she is taught that unless she keeps her home clean she can't teach her patient to be clean. On a case she wears a cap, gown, and mask. This is added protection to mother and baby.³⁶²

The purpose of the appropriate midwife attire was for the sterility of the birth environment. The midwife was not only to maintain clean equipment, but was to be clean in person and clothing; in addition, her private dwelling, a place where no births, except possibly her own were to take place, was to be kept clean as well. As the article states, she was to set an example of cleanliness to the mothers in her community. The focus the health department maintained on cleanliness was a statement of their political and social position as well as a health issue. The nurses and doctors involved in midwife education were interested in maintaining an image of the type of births they

³⁶² "Amite County Midwives" (MDAH, RG 51, Loc 11-19-1, Box 8407, 1012:27).

were responsible for. Despite the fact that many midwives and mothers had trouble maintaining the sterile conditions imposed upon them, the health departments of the South focused, in their public statements, on the sterility of the birth experience under their care. The birth experience before regulation was depicted as dangerous, superstitious, and dingy. After regulation, it was portrayed as not only cleansed of dirt and grime, but of the “backward” superstitious practices of the older type of midwife. In reality, some midwives were able to maintain sterile practices and some were not, but most retained a remnant or two of the tradition-based system. The passage under the photo reads:

Last fall there were so many babies in Tampa who died or were blind that the work of the midwives was called to the attention of the city physician. Through his efforts and those of the District Nursing Association an ordinance was passed, ordering all midwives to be registered further stating that they could not register until after they had taken a course in Hygiene and Midwifery and had passed an examination in this class of work. The course has been rather difficult because few of the women read or write.³⁶³

Although the accompanying article describes the work of a nurse in South Carolina, the photograph describes a program in Tampa, Florida. Midwives and the training programs in the South were considered interchangeable and not distinct in public discourse. Certainly it could be said midwives throughout the South faced common challenges and shared common techniques and traditions. However, as the previous chapters have demonstrated, their reactions to regulation were different over time and space, yet the language used to describe them was identical.

The Mississippi Department of Health used, throughout its publications, descriptions of the ways in which midwife organizations had been transformed through their intervention. Within a

³⁶³ Dodd, “An Open Air Class.”

description of midwife club work in the state, one publication described the change in these words:

The type of meeting gradually changed from a chaotic, disorderly group of women dressed in clothes of all descriptions including woolen dresses and fancy hats, many talking and paying little attention, to midwives dressed in clean white uniforms and white caps, several helping to inspect bags and keep order, all attentive and eager to learn.³⁶⁴

It was important that the Department of Health in Mississippi emphasize that the midwives were originally a “chaotic” group, but were now clean, orderly, and attentive. They were portrayed as following all the instructions put forth by the health department and doing so with enthusiasm and willingness. This is a very different image from those seen in individual records, as described in Chapter Four. The midwife record cards kept in Alabama showed that some midwives were difficult to control and often operated independently and without regard for the rules imposed by the health department. Many midwives who were active during the years of the Great Depression were unsupervised and left to their own resources. Others were simply defiant of health department codes of conduct. It was important, however, in these types of public discourse for the health departments of the South to demonstrate the level of control they had over area midwives through words and photographs.

Public descriptions of the 1940s and beyond focus on the transformation that occurred among midwives, from being disorderly and slovenly to being orderly and proper in appearance. A 1950 newspaper article entitled, “Forrest County’s Midwives Do Their Job Well,” is another example of this type of discourse. The article describes a midwife meeting at the Mount Carmel Baptist Church. The meeting opened as “the 19 white-uniformed negro women stood stiffly at

³⁶⁴ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health,” January 1, 1944 (MDHA, RG 51, Loc 11-18-1, Box 8416, 36).

attention as Patsy, the oldest of the group, started a song in a high plaintiff [*sic*] voice.” She and the others sang, “with religious fervor,” the marching song of the midwives. They had then received a talk on “better methods of delivering babies” and a demonstration on “proper foods for mothers.” The women present were described in the following manner:

The neat, alert women whose licenses were renewed this morning were a strong contrast to the untidy, superstitious and illiterate negresses who were the typical midwives of the 20’s. The old negress in a dirty nondescript dress, a pipe stuck in her mouth and a few odds and ends of equipment thrown into a paper shopping bag has been replaced by a cleaner women in a white starched dress and cap who carries a neat leather doctor’s bag and regularly-inspected supplies.³⁶⁵

The article makes it clear, however, that although the women were well trained and had an appearance of professionalism, the system of supervision and “occasional scolding” by the nurses had not made “doctors out of the midwives.” The health department still received troubling reports, such as one that “a midwife insisted on a mother wearing her husband’s hat during delivery to make her labor easier, or that she was directed to eat only tea and toast for a week after her child was born.”³⁶⁶ These practices were part of the traditional system of practice that all health departments had focused on eradicating. It shows that although a group of midwives may be well trained and supervised, they had not entirely let go of their traditional beliefs. Further, they were still likely in this time period to give God credit for their entrance into midwife work. A midwife interviewed for the article stated that, “she learned her trade in a vision from God,” but that she also considered the health department training to be a “great idea.” These statements reflect the merging of the past of African-American childbirth

³⁶⁵ “Forrest County Midwives Do Their Jobs Well,” August 23, 1950 (MDAH, RG 51, Loc 11-18-1, Box 8416, V.36).

³⁶⁶ Ibid.

experiences with the future. Although there were some who shunned the “superstitious” ways of the past, most openly acknowledged the past while embracing the future. The fact that midwives of the 1940s and 1950s were able to adapt themselves to modernization does not mark a departure in the history of childbirth practices in the South. It is rather, a continuation of a the tradition of midwifery in which they had, in all periods been willing to embrace new techniques, ideas, tools, and concepts, as long as they were able to simultaneously maintain aspects of their traditional practice. Sometimes they did this openly, and sometimes it was covert and created tension between themselves and the nurses and doctors they worked with.

African-American midwives who practiced during the 1940s were likely to be depicted as simultaneously embodying modern and antiquated methods of practicing. An article written by Mamie O. Hale, a certified nurse-midwife for the Arkansas State Board of Health, described how midwives in the mid 1940s identified those who they considered to be practicing according to modern guidelines and those who were maintaining an outdated system. In this example, a nurse-midwife is providing instruction to the local midwives. In order to explain the changes in methods of delivery, she makes the analogy that their methods of transportation had evolved from “stage coach and horse and buggy.”³⁶⁷ These had been replaced by “train, automobile, and airplane.” The purpose was to help the midwives understand that changes in the type of instructions and methods of practice were necessary if the woman wanted to be considered a “modern, or airplane midwife.” The article states that “often times, later in the classes, a midwife

³⁶⁷ Mamie O. Hale, “Arkansas Teaches Her Midwives,” October 1946 (NA, Folder “Midwife Education,” 4-1-1-6, Box 86, 1945–1948).

will, in reporting another midwife as backward, say, ‘Nurse, such-and-such a midwife is still a horse-and-buggering,’ meaning she is failing to follow some of the new teaching.’³⁶⁸

It is clear that in this time period there were a multitude of images of the lay midwife that were being distributed throughout health-care and mainstream publications. There were often very different portrayals in the same document. An article written about midwives in Louisiana is similar to that of the Arkansas document in its image diversity. The use of dialect is present in this article to make a point about the socioeconomic status of the lay midwife. An excerpt follows:

A familiar picture is that of an aged, decrepit negro women in a dark dress and white apron, with her head covered by a white headrag or scarf, smoking a pipe or holding a wad of Garrett snuff in her lip, walking along the road and being cordially greeted by both Negroes and whites whom she takes pride in having brought into this world. One often hears the passerby’s familiar greeting, “Good morning, Granny, how is you?” and the reply, “I’s feeling poorly child. What you gwine to gimme today?” Usually this beggary brings reward such as a soda pop, two bits, or even six bits during harvesting time.³⁶⁹

This depiction of an antiquated, impoverished lay midwife is immediately preceding a description of midwives facilitating their patients being seen by private physicians and at maternity clinics. According to the article, the typical midwife in Louisiana “has learned that antepartum patients applying to her for delivery fare best when medical care is given early in pregnancy by competent persons.” Her influence in the community is not limited to childbirth, according to the article, “since she also assists by sending crippled children and well babies to child health conferences: and by using her home as a center, she gathers the children in the community for immunizations against diphtheria, smallpox and whooping cough.” Midwives are

³⁶⁸ Ibid., 2.

³⁶⁹ Lange, “Louisiana Midwives” (UAA, Folder 4.62), 10.

portrayed as actively participating in the health-care programs of their time and encouraging the improved health and well-being of people in their communities. It also depicts women who were influential enough in their communities to facilitate change. It seems like a different group from those who were portrayed as commonly asking for handouts from their neighbors, yet the two descriptions are side by side.

One of the ways in which midwives of the South maintained a traditional aspect to their work through the middle of the twentieth century was through their beliefs in the spiritual aspects of their work. The midwives depicted in the article from Arkansas had taken to writing after their signature, “A midwife of the State and from God.” Although they increasingly identified with the health programs of the state, they were unwilling to abandon their identities as spiritual practitioners. The article includes an extended articulation of this belief:

Many say that they have received their gift from God. “No man can teach over God,” they say. They tell of being called in a vision. A common vision is the appearance of an angel dressed in white, who visits them night after night making cutting motions with the finger—symbolizing the cutting of the cord.³⁷⁰

This description of having received a vision and receiving a calling remained unchanged throughout the twentieth century. Despite the increased presence of health officials, the presence of trained nurse-midwives, and the acceptance of modern methods of practice, African-American midwives of the South maintained a continuous and firm belief in the spiritual aspects of their work. Furthermore, their spiritual beliefs functioned as an inner compass, directing them in how to interpret the new information they were receiving. The article goes on to quote midwives as saying that they feel “justified in resisting the teaching of the health department since, ‘God

³⁷⁰ Hale, “Arkansas Teaches Her Midwives,” 5.

himself gives us instructions directly.”³⁷¹ The further they became involved in their training, they came to interpret things differently. According to a description of the Arkansas midwife program, most “come to believe that the new instructions are some extra enlightenment sent by God and that the health department is really an instrument of the Lord.”³⁷² In this way the midwives in Arkansas were able to embrace the new training and see themselves in a more modern light, while maintaining the core of their traditional practice: their spiritual beliefs.

However modern the lay midwives of Arkansas and other Southern states were beginning to be portrayed, health publications of the time period maintained a clear distinction between the traditional lay midwife and the nurse-midwife in terms of how she was photographed and her appearance. The Bulletin of the Tuskegee School of Nurse-Midwifery included visual portrayals of the traditional midwife and the Tuskegee-trained nurse-midwife. The second page of the Bulletin, published in 1945, consists of a photograph with a caption that reads, “Nurse-midwives work with lay midwives.” The photograph shows two women standing next to each other. The Nurse midwife is wearing a knee-length dress, with a white collar, tie, and handkerchief in the pocket. Her hair is pressed and curled, she is wearing high-heeled shoes and stockings, and she is carrying a large, leather doctor’s bag. The lay midwife standing next to her is very different in appearance. Despite the fact that most lay midwives of this time period wore starched white uniforms and caps, this woman is very rural and nonmedical in appearance. She is wearing a wool cap, ankle-length cotton dress, sweater, and work jacket. Her clothing looks very ragged and worn in appearance. She is wearing large leather work boots, and carrying a smaller and less-polished doctor’s bag than the nurse-midwife. The lay midwife has a dark-brown

³⁷¹ Ibid.

³⁷² Ibid.

complexion and is not smiling, the nurse-midwife is lighter-skinned and has a slight smile. The nurse-midwife looks modern and fresh; she has a professional appearance. The lay midwife looks like a rural worker, and lacks a visible marker of being a health-care worker, except for the leather bag. She does not look clean or professional in any way.

The above portrayal of the lay midwife was intended to highlight derogatory stereotypes of the “granny midwife” as being unclean and unsafe. The nurse-midwife was intended to appear as a much safer alternative. The first page of text in the manual states that “the certified nurse-midwife, working under medical guidance, can do much to improve the health of mothers and children.”³⁷³ The idea behind the photograph and the accompanying text is that while the nurse-midwife could not replace the traditional midwife at that time, she was to be seen as a savior of women, and a much more desirable, modern alternative. It is clear that the visual discourse of the nurse-midwife portrayed her as having a middle-class identity and appearance. The lay midwife in this image has the appearance of an agricultural worker, and she most likely was one. What is striking about this example is that there were many lay midwives in the time period of the 1940s who had already abandoned this type of attire for midwife work. They were a highly organized group with clubs, leaders, records, and white uniforms. Yet, the Tuskegee Institute, in order to make a point, chose a woman who did not bear any resemblance to the organized lay midwife in appearance. They wanted to portray a “granny” to display the marked differences between the women they were training and the women from the larger community. They were able to do this most effectively through the visual discourse described here.

³⁷³ Tuskegee Institute, “Bulletin of the Tuskegee School of Nurse-Midwifery,” 1945 (TUA, Records of the School of Nursing).

Another edition of the Tuskegee Bulletin follows the same pattern of portraying the marked differences between a lay midwife and a nurse-midwife. In a section titled, “Going on a delivery,” two pictures appear side by side. The first, which is captioned, “Granny,” shows a woman very similar to that of the lay midwife in the previous description. She is wearing a long cotton dress, wool cap, sweater, and boots, and is standing near a home with an open wooden porch. The second photograph, captioned “Nurse Midwives,” shows two nurse-midwives standing next to an automobile and a more modern-looking home with an enclosed porch. They are wearing modern knee-length dresses with white collars. The text following the photographs reads:

The granny is doing her best for the mothers. She provides care for mothers who would not have any care at all if she did not give it, but the best often includes many dangerous procedures such as vaginal examinations done with an unwashed hand and greased with lard, deliveries on the bare floor, the use of dirt dauber tea, and the adherence to a wide variety of superstitions. Underprivileged sharecropper mothers send to nurses their earnest appeal for help—to save their lives and those of their babies.³⁷⁴

The above text makes it clear that the lay midwife was associated with backward practices and folk belief systems that were considered dangerous to mothers. An article from Arkansas, published two years later than the Tuskegee Bulletins, stated that the midwives there were “extremely superstitious and bring their superstitions into their midwifery,” but that they “enjoy also in the community a special position of respect comparable to that of a preacher, a teacher, or any other community leader.” The article goes on to state that “generally speaking, the older the midwife the more confidence the community has in her.”³⁷⁵ In some cases women did prefer an

³⁷⁴ Tuskegee University, “Tuskegee School of Midwifery for Colored Nurses,” 1944 (TUA, Records of the School of Nursing).

³⁷⁵ Hale, “Arkansas Teaches Her Midwives,” 1.

elder midwife over one who had the appearance of training. In the following example, a mother-in-law shows preference for an elder midwife.

It soon became evident that the mother-in-law was worried about the birthing of this first grandchild of hers and did not completely trust Mary Belle. She would have preferred an older midwife and one who did not look and act so sprucy and up-to-date.³⁷⁶

In this passage, the mother-in-law expresses concern that the midwife in attendance has an appearance that she associated with modernity and training. This was not her preference. However, her daughter in law who was in labor did not object and Mary Belle continued with the birth. In fact her practice combined traditional techniques with modern training. She did make sure that the birth area was clean, and she rubbed the newborn with oil as instructed by the public health nurse. However, she also prescribed, “white cloth fried in cow tallow flavored with camphor and turpentine and laid on hot,” in the case of abdominal cramps in the mother.³⁷⁷

Photographs that accompany the text in an article written about Arkansas midwives are quite different in tone from those published in the *Tuskegee Bulletin*. The first photograph has the caption, “gathered around the table, the midwives listen to the nurse-midwife, who is telling them how important the birth certificate is.”³⁷⁸ The photographs show the nurse midwife, an African-American woman dressed similarly to the women from Tuskegee. She is wearing a simple, but modern-looking dress with a white collar, and her hair is pulled back. The lay midwives are very different, however. They are seated around a table, wearing white gowns, and caps, and are inspecting papers held in their hands. While there is a difference in appearance

³⁷⁶ Mary Campbell, *Folks Do Get Born* (New York: Garland Publishing) 1946. 68.

³⁷⁷ *Ibid.*, 70.

³⁷⁸ Hale, “Arkansas Teaches Her Midwives,” 1.

between the nurse-midwife and the lay midwives, they all have the appearance of health workers and seem professional, clean, and literate. In addition, there is a photograph of a midwife who has been “taught to sterilize the removable cotton lining of her bag before packing it to go on a maternity case.”³⁷⁹ The woman in this photograph is also wearing a white apron, collar, and white cap. The final photograph is that of a midwife, “at the local office of vital records,” where she is “handing in a birth certificate that she has made out for a newborn baby.”³⁸⁰ All of these activities and images portray midwives following the procedures taught them by the local health department. They are all intended to show the improvements that had been made through the work of health officials, yet are not derogatory toward the midwife in any way. While the time period is not markedly different from the Tuskegee publication, the tone and the sentiment are. It is possible that the Tuskegee Bulletin reflected the sentiments of Tuskegee officials who were more in keeping with the ideology of the early 1920s, or that since the program was unstable and in its infancy they needed to justify it through propaganda and stereotyping. Whatever the reason, it is clear that at this time there was a widely diverging set of images and portrayals of the traditional midwife. The visual discourses of the time period tell a story of a pervasive stereotype that was in its final throes. While the idea of an illiterate, unclean, folksy “granny” was familiar to many health-care workers and mothers, in actuality the women who were still attending the vast majority of births in the South resembled that image less and less.

During the 1940s it became more likely that a pregnant African-American women in the rural South would attend a clinic or a maternity conference organized by nurses or midwives. At this time she would be examined by a physician and checked for any abnormal health conditions.

³⁷⁹ Ibid., 4.

³⁸⁰ Ibid., 6.

There are abundant descriptions of such maternity conferences at this time throughout the South. The annual report conducted by the health department of Greenville, Mississippi in 1941 describes such an occasion.

In recent years the health department has conducted an extensive prenatal program designed to assist those who cannot afford the services of a private physician. Since only a very small percentage of midwife cases are white, this work is almost entirely with negroes. During this year we were able to render some service to over 80% of these cases. All expectant mothers are urged to report to the closest clinic as early in their pregnancies as possible. At this time each woman is given a careful medical examination, including weight, blood pressure, examination of urine, blood test for syphilis, smear for gonorrhea, pelvic measurements, and a complete physical and pelvic examination.³⁸¹

In Greenville County, 69 percent of the total number of births were attended by midwives in 1941. The midwives were described as being, “untrained in medical science,” and the need for medical supervision over this group was deemed “urgent,” by the health department.³⁸² The language of the report focuses on the need for medical examinations among the prenatal patients, and the health department’s success in seeing such a large percentage of women over the course of the year. Most prenatal patients were seen by a doctor through the encouragement of their midwives, yet they are not acknowledged in this report except to point out the poor quality of their service.

Most official reports and descriptions of such maternity services were accompanied by photographs of the conference itself or with a photo intended to highlight some aspect of the work in that county. The annual report of Washington County, described above, included a photo of five midwives standing in two rows. They are wearing the white apron dresses and caps that were markers of the regulated midwife. Several of the midwives are also carrying the black

³⁸¹ Health Department, Greenville, Mississippi, “Annual Report Washington County, 1941–42” (MDAH, RG 51, Loc 22-25-1, Box 8710, 2031:311–312).

³⁸² Ibid.

leather doctor's bag, common in such images. Although the women in the county were described as being "untrained in medical science," it is clear from the photograph that they have undergone some form of medical training through the health department. The women are neatly arranged and posed, and they are wearing the uniform of the midwife in training. Yet the report states that they are badly in need of some type of medical supervision. The visual image makes it seem as if they were already under supervision by a nurse. Despite the wording and description of the midwives, most photographs associated with medical clinics were meant to give the impression of an orderly reform movement. This article is unusual that it does not give any credit to the midwives who were usually responsible for bringing their patients in to be seen by a physician. The language used here is a holdover from the type of derogatory discourse used so often to describe midwives before the regulation period. The language had not caught up with the reality of conditions in the Mississippi county.

More commonly, midwives are given partial credit for attendance at prenatal clinics, or at least mentioned as being present. In Sunflower County, Mississippi, a 1936 report states, "Maternity conferences are held each month in five localities ... [on] set dates."³⁸³ The description goes on to state that "patients are brought to the conferences by their midwives."³⁸⁴ The women who were seen were given tests for venereal disease, and their blood pressure and pelvic measurements were taken. The eighty-three active midwives in this county had delivered the majority of babies that year, and were supervised by the public health nurses assigned to the area. In a 1941 report of the maternal hygiene program in Coahoma County, midwives are also given credit for the participation of their patients. According to the report, "[T]he midwives have

³⁸³ Sunflower County Health Department, "Sunflower County Annual Reports, 1936–1937" (MDAH, RG 51, Loc 22-25-1, Box 8710, 2031:311–312).

³⁸⁴ Ibid.

rendered a most praiseworthy service in getting their antepartum cases into the medical clinics in the early months of gestation.” Most women were seen in the third and fourth months of their pregnancies.³⁸⁵ The health department officials in this county stated that they felt it unlikely that nurses would replace the midwives in attendance at births “because of the large Negro population.”³⁸⁶

As with other descriptions of the maternity conference, there is an accompanying photo that is meant to contribute to the description given in the text. The Sunflower County report includes a photograph of women at one of the maternity conferences held in the county. The caption reads, “A group of mothers, infants, and midwives at a conference.”³⁸⁷ In the photograph, there are several women who can be identified as midwives because of their dress. They are wearing white aprons and caps. They are standing among many other women who are holding babies or are accompanied by older children. They are, as in most photographs, outdoors in a park or other type of open area. The photograph has the feeling of a picnic or community gathering. There are no medical professionals present in the photograph. This image is meant to highlight the attendance of midwives and prenatal and postnatal women at medical conferences. Although the purpose was medical, the sense of the gathering is communal. These clinics were some of the first occasions for African-American women of the South to be seen by a physician and to have contact with modern medical examinations, and the experience occurred because of the encouragement of midwives, who continued to be described in some instances as backward and

³⁸⁵ Coahoma County Health Department, “Annual Report Coahoma County Maternal Hygiene, 1941” (MDAH, RG 51, Loc 22-25-1, Box 8710, 2031:311–312).

³⁸⁶ Ibid.

³⁸⁷ Sunflower County Health Department, “Sunflower County Annual Reports, 1936–1937.”

problematic. Yet they were responsible for gently urging the women under their care into a more personal connection with modern medicine.

In some reports, photographs are more distinctive than text. The text in the annual report of Lauderdale County, Mississippi in 1939 is not remarkable: “maternal medical and nursing conferences were held in different points in the city and county.”³⁸⁸ The mothers who attended the conferences received a similar assortment of routine exams as those in the other counties. The report states that “the activities of the midwives are actively supervised by the public health nurses. The nurses also conduct ... classes for them requiring them to attend, attempting to teach them the elementary principles of attending expectant mothers at delivery.” This text is very similar to descriptions of maternal conferences in other counties. A description from Coahoma County is almost identical. It states that the midwife service in this county was a “necessary evil,” and that the health department feels that it was “protecting the public health” by closely supervising and providing instruction to the midwives of the county.³⁸⁹ The photo in the report from Lauderdale County, of a “group of Negro Midwives,” shows a large group of midwives, all wearing white uniforms and carrying black leather doctor’s bags, posed in front of a brick building in an urban setting.³⁹⁰ This photo has a different tone than those of midwives and women together in rural settings and open areas. The report from Coahoma County, for example, shows an image of midwives and childbearing women. The midwives are standing behind a row of women seated on the grass in front of a wooden structure. In another

³⁸⁸ Lauderdale County Department of Health, “Annual Report of Lauderdale County, 1939” (MDAH, File “Maternal, Infant, and Preschool Hygiene,” RG 51, Loc 22-25-1, Box 8710, 2031:311–312).

³⁸⁹ Coahoma County Department of Health, “Annual Report of Coahoma County Health Department, 1938,” pp. 311–12 (MDAH, Coahoma Co. Annual Reports, 1935–1940, RG 51, Loc 22-25-1, Box 8710).

³⁹⁰ Lauderdale County Department of Health, “Annual Report of Lauderdale County, 1939.”

photograph of midwives only, six women wearing white dresses and caps and carrying black leather doctor's bags are standing in a row in front of a wooden house.

African-American midwives did not only attend maternal health conferences in the 1940s with their patients, they often hosted such meetings in their own homes. A 1944 report made by the Mississippi State Board of Health describes several midwives who held conferences in their homes. One midwife is described as coming from “quality folk,” and being well spoken, although unable to read or write, and as being appreciative of the instructions given to her. This woman was a respected member of the midwife community and was followed in the practice by both her daughter and granddaughter.³⁹¹ She “opened her home for antepartum medical conferences for midwife cases, conducted by the county health department.”³⁹² She brought twelve of her own cases to the conference on the first day, and continued to provide her home as a venue and midwife services for antepartum medical conferences for the next four years.³⁹³ Another midwife is described as having an interest in the medical conferences that was so keen that she also offered her home. She was “lacking a kitchen table that was big enough. She had a special examining table built. Fifteen antepartum and two postpartum cases and four babies were examined at the first medical conference.”³⁹⁴ A medical conference was held in the home of another midwife where the nurses and doctors found a home filled with patients and everything “conveniently arranged.” The health department nurses noted that “the last few examinations

³⁹¹ Mississippi State Board of Health, “The Relation of the Midwife to the State Board of Health,” January 1, 1944 (MDAH, Public Health Nursing, Correspondence, Memoranda, and Reports Documenting the History of Public Health Nursing [Principally Midwifery] in Mississippi, 1930–1950, 1 of 2, Loc 51:8416:11-18-1:36.

³⁹² Mississippi State Department of Health, “The Relation of the Midwife to the State Board of Health,” January 1, 1944.

³⁹³ Ibid.

³⁹⁴ Ibid.

were done under difficulties. The hour grew late and two midwives with kerosene lamps held aloft, supplied the light while the last patients were given medical examinations.”³⁹⁵ African-American midwives did not play a passive role in the medical conferences of their time. They were active facilitators in the increasing medical observance of their patients.

Participation in maternal health programs was not a departure for them, in terms of their theoretical outlook on the birth experience. They had a long history of being open to the medical world and being a part of that world. Before the period of instruction, they had worked closely with doctors, and in the early phases of supervision they were likely to embrace training programs. By 1944 they had experienced decades of often extreme surveillance of their work and had settled once again into a pattern of partnership with the medical professionals among them. Their primary goal in all eras was the health and well-being of mother and baby. Circumstances surrounding this goal had changed drastically since the nineteenth century. The interconnected goals of consideration for the patient’s health, and unwillingness to neglect the spiritual aspects of the work that determined midwives’ reactions to medical professionals. In circumstances where a midwife felt her ability to provide care was compromised, she would resist. If she felt that the rules imposed on her limited her ability to provide the proper spiritual environment for a mother under her care, she would either openly or covertly resist them. If, however, she was presented with an opportunity that would increase her ability to care for the women of her community, it was almost universally embraced. African-American midwives’ active role in the maternal health conferences of the 1940s is a perfect example of such opportunities.

³⁹⁵ *Ibid.*

The role that midwives played in seeing that their patients be examined at these conference did not go unnoticed by the medical professionals around them. They recognized that it was the midwives who were encouraging their patients to be examined, not just for maternity concerns, but for a wide array of medical issues. According to the director Mississippi State Board of Health epidemiology division:

Mississippi, as with other southern states, was due for a rise in the incidence of typhoid fever in 1930. There was however a reduction in cases instead. It is believed that midwives played no small part in holding down the typhoid fever rate, because through the efforts of the midwives as urged by the leaders of the midwife clubs, thousands of negroes were inoculated [*sic*] against typhoid fever. One midwife leader brought three hundred, another two hundred, to these conferences.³⁹⁶

African-American midwives actively participated in efforts to gather information and improve the health of all people in their communities, but particularly that of women and children. The 1944 report notes that they helped facilitate studies conducted by the Commission for the Blind, and a survey of the disabled population by the vocational bureau of the Department of Education. They also aided in venereal disease surveys and in tuberculosis studies conducted in various counties in Mississippi. They “assisted county health personnel at infant, preschool, and antepartum and postpartum medical conferences and sent thousands for protection against smallpox, diphtheria, whooping cough, typhoid fever and treatment for venereal diseases.” The same report also notes that midwives were instrumental in bringing about improved sanitation in homes in their communities.³⁹⁷ They did not limit their activities to maternal health and the delivery of babies. Whenever possible, they took an active role in spreading health-care

³⁹⁶ Mississippi State Board of Health, “The Relation of the Midwives to the State Board of Health,” January 1, 1944.

³⁹⁷ Ibid.

information and encouraging women and children to participate in programs that would improve their health. The staff of one local health department noted that while they were working diligently to educate the public about the dangers of venereal disease, it was felt that they were getting additional help from an outside source. It was later discovered that, “a leader of a midwife club who had received literature on syphilis had made talks at churches, schools, and in girls’ homes. This midwife was instrumental in sending in several young girls under sixteen years of age who had infectious syphilis and were placed under treatment.”³⁹⁸ The midwife in this example illustrates that the concern for women during the birth experience, led many African-American midwives to extend their work to all possible aspects of women’s health. Venereal disease was a particular area of concern, as midwives witnessed first hand the devastating effect it had on the mortality rates of black infants in their communities. In this time period, syphilis in particular impacted the health and well-being of large numbers of women and infants. In 1941, it was estimated that syphilis caused 21 percent of African-American stillbirths.³⁹⁹ In response, midwives were adamant that their patients receive treatment whenever possible.

African-American midwives of the South were swept up in the national spirit of duty and obligation to public service that was common after World War II. They were encouraged to believe that they were participating in a widespread effort to uplift the nation and its people. The “Song of the Midwives,” which was sung during midwife gatherings reflects the enthusiastic

³⁹⁸ Ibid.

³⁹⁹ U.S. Children’s Bureau, “The Health Situation of Negro Mothers and Babies in the United States: A Brief Statement of Health Status, Health Services and Needs,” March 1941 (MDAH, Loc 51:8407:11-19-1:1012:27). The other highest leading causes of stillbirth were placental and cord conditions (21%) and toxemias of pregnancy (12%).

spirit of midwife work during the 1940s. The following lyrics were sung to the tune of “As We Go Marching On.”

We aim to be good midwives of the State, we try hard to be up to date.
To be on time to meetings, and never to be late, as we go marching on.
We put on water in a great big pot, we know of this we must have a lot
We boil it all, use some cool, some hot, as we go marching on.
We put drops in the babies’ eyes, whether the mother laughs or cries.
The state for us the eye drops buys, as we go marching on.
We report births and deaths of all, when anything is wrong, we the doctor call.
We hope never from grace to fall, as we go marching on.
We wear clean dress, clean cap, clean gown, we have clean homes, clean yards, clean
town, we make our country renown, as we go marching on.
Our county midwives are the best in the state, they try hard to be up to date.
Are on time to meetings, and never are late, as they go marching on.

The midwife song was intended to reinforce some of the basic regulations put forth by the health department, such as accurate recording of births and the use of eye drops in newborns. However, it was enthusiastically embraced by midwives, as it was a chance for them to demonstrate their commitment to a safe birth and to join in the spirit of optimism and good health that had spread throughout the nation. It helped foster pride in their work. They felt that they were a part of improving the health and well-being of their communities, and they were.

Songs that were frequently sung by midwives were considered a distinct and exclusively black aspect of Southern culture. In 1937, John Lomax, curator of folk songs for the Library of Congress went to Mississippi to record some of the state’s original folk music. After making three annual visits to the state penitentiary to record, “the vanishing folk songs of the Mississippi

negro,” he asked to do a recording session of midwives at the State Board of Health offices.⁴⁰⁰

After recording the midwife songs, a Mr. Lomax “sealed in black wax their lullabies, three negro women offering their own, handed down to them from their own mammies.”⁴⁰¹ According to the article,

Georgia Spann Baymore ([s]he’d have more names than that if she included the names of her five husbands), was the star of the recording. Her old eyes and her incredibly black face lit up as she sang her lullaby, “De One I Put White Chilun Ter Sleep Wid,” and as she rollicked through “Run, Nigger Run, De Patter-Rollers’ll Git You!” Sometimes laughing ..., but never missing a rhyme, even when in the presence of white folks, she had to improvise ones she considered more suitable for their ears.⁴⁰²

The description of the recording session is thickly layered with the racial stereotypes of African-American women that were common in public discourse of the time. But the fact that the recorder from the Library of Congress chose the songs of federal prison inmates and female midwives indicates that these two were considered the archetypal male and female figures of the black South by white officials. The female counterpart to the prison inmate was the happy, elderly “granny.” Both were being closely monitored by the state, and were at times considered dangerous and a threat to the public. Yet if they were within a controlled environment, both groups could be viewed in a nostalgic light, and as a dying part of Southern culture.

As time passed, the imagery used to describe midwives and childbirth became mixed and inconsistent. There were many cases where midwives were portrayed as backward and ignorant in the same document that they were given praise for accepting new training methods and

⁴⁰⁰ “Song’s recorder here—Curator Hails ‘Pen’ music—Midwife Song Taken,” March 9, 1937 (MDAH, Loc 51:8416:11-18-1:36).

⁴⁰¹ Ibid.

⁴⁰² Ibid.

techniques. This mixed imagery is indicative of the transitional nature of the time period.

African-American women were being seen on a much more frequent basis by physicians for at least one prenatal testing exam through the encouragement of their midwives. Midwives were becoming more active in all types of health-care campaigns. African-American physicians began to show increased interest in attending women in childbirth, both in hospitals and at home. In some communities where such services were available, women began to go to black-run medical facilities for their births. These are all indications that change was occurring.

African-American women were far more in control of these shifts than previous studies have indicated. Health-care workers concluded early on that midwife-attended home births were dangerous for the mother and infant. However, this opinion did not sway the actions of black childbearing women of the South. They continued to rely on the services of lay midwives for many decades after this discourse had become widespread. One of the primary reasons for this was the fact that midwives were determined to maintain their core belief system and approach to birth. They viewed it as a spiritual experience, and one that should not be approached in the absence of God. This seemed to resonate with the women they served; traditional methods of practice were a source of comfort and continuity for women, and thus highly valued. African-American midwives accepted or rejected new training methods according to their personalities and background, the approach of the instructor, and to what extent they were able to do so while maintaining traditional methods. Childbearing women chose to accept or reject hospital births according to their own standards as well. The presence of a black-run hospital did not in all cases lead to a large shift from home to hospital births. Staff at Tuskegee's John A. Andrew Hospital had a difficult time attracting women to its maternity wards, while the Slossfield health center

was more successful. This may have been due to the fact that Tuskegee served a strictly rural population, and Slossfield was in closer proximity to Birmingham, Alabama's largest city.

CONCLUSION: A NEW RELATIONSHIP TO MODERN MEDICINE

*I used to tie the cord with any old string I could find, and mix grease and soot to put on it, and cover it with whatever rag was handy. It makes me tremble now to think how many germs I used.*⁴⁰³

*Under the Old Law we never done anything like this. We just used any old things, dirty or clean. One time a woman told me to get a piece of old quilt off the porch. Old dog Tige was lying on it, but I kicked him off and put that dirty piece of quilt on the woman's bed. Scares me now to think what I done.*⁴⁰⁴

From interviews with lay midwives – Georgia, circa 1946

As the second half of the twentieth century approached and passed, a considerable shift had occurred in the experience of childbirth among southern black women. The midwives quoted in the opening of this section, expressed feelings of fear when describing the unsanitary practices of their past. The feelings of women regarding the approach of modern medicine into their mothering and childbirth experiences continued to be mixed throughout the course of the twentieth century.

One woman, the daughter of a woman who had been born at home and who had five of her six children born at home, for example, took a stand against using traditional folk medicine on her child.

There had been some conflict between mother and daughter on that afternoon about the treatment of Mikey's thrush infection. 'I am going to use modern medicine,' Josie had said. 'Mama isn't going to use any of her 'slavery medicine' on my baby.'⁴⁰⁵

⁴⁰³ Campbell, 29.

⁴⁰⁴ Ibid. 34.

⁴⁰⁵ Loudell Snow, *Walkin' Over Medicine* (Boulder: Westview Press) 1993. 24.

This passage indicates a significant generational shift that had taken place by the final decades of the twentieth century, when this statement was made. There were also examples of women who continued to find some comfort in traditional practices within the hospital setting. An example from Lansing, Michigan in 1975 is indicative of this shift as well. The hospital staff there never noticed that a young patient by the name of Arelene Bauer had received a special gift from her grandmother who came from West Virginia to visit her while she was giving birth. “Arlene Bauer’s grandmother had a hatchet in her knitting bag when she came to visit her granddaughter and great-grandson. The old lady brought it all the way from her home in West Virginia and merely slipped it under Arelene’s mattress when no one else was around.”⁴⁰⁶ When asked if the traditional cure had worked to ease her labor pains as was intended, she responded, that “it cut those pains right in half.”⁴⁰⁷

A young woman who had just given birth in the hospital listened to instructions on how to care for her newborn. After hearing the instructions on how to care for the umbilical cord by the pediatric nurse practitioner she asked the following question: “After it falls off, do I have to burn it up to keep something bad from happening to my baby?” She told the nurse that she had been given these instructions from her grandmother. The nurse replied that, “Doctors and nurses don’t think that it is necessary. But it can’t hurt anything. If it makes you and your grand mother feel better, by all means do it.”⁴⁰⁸ The young mother appeared to be relieved by this reply from the nurse.

Other women maintained a preference for the home birth setting despite the growing number of African American hospital births. Loudell Snow provides us with the testimonies of several

⁴⁰⁶ Loudell F. Snow, 211.

⁴⁰⁷ Ibid.

⁴⁰⁸ Ibid., 228.

generations of black women who maintained a strong preference for home births throughout the later part of the twentieth century. Bernita Washington is a woman who was steeped in the traditions of folk medicine. In an interview taken in 1986 she discussed these preferences.

I have what you call migrain headaches and I never have found, doctors never have found a cure for it, you know. But you can use it (Aloe Vera leaves) for that. But sometime it doesn't work as well as peach tree leaves. A peach tree that you gather peaches from, you use the leaves.⁴⁰⁹

When asked why she did not take the migraine medicines prescribed to her by a doctor, Bernita replied that, "you really don't know what's in it.." and that the doctor's medicines could be "too strong."⁴¹⁰

Bernita had her first child at home, unassisted, when she was just sixteen years old. She described the birth experience in the following way:

O.K., so then you call in for the midwife [once she began having labor pains] either late night of the next day, 'cause they are trained. They are just like doctors, you know. Really, when Marya was born wasn't anybody there! They was on their way after the midwife. All by myself, 16 years old, that was Marya.⁴¹¹

When asked if she had been scared during the birth, she replied that she was not. She had been told what to do in just such a case by her sister in law. "I was taught by my husband's sister; my husband's sister would tell me how to do and what to do if I was there by myself."⁴¹² Perhaps her sister in law had been unassisted herself, or felt that it was likely due to the family's location. Bernita seemed to have been comforted by the information.

⁴⁰⁹ Ibid., 22-23.

⁴¹⁰ Ibid.

⁴¹¹ Loudell Snow, 211.

⁴¹² Ibid.

The baby that Bernita had that day, Marya, grew up to have her own preference for home births and traditional healing methods. She had been transported to the hospital for one of her births. She described her feelings about the hospital setting.

I don't like the hospital; I'm afraid of hospitals. I wouldn't have went with Sonny but I had to, down South. I had to because I had a hemorrhage before the baby was born...But I'm afraid of the hospital; I think I like the midwife better...I think I'd rather be at home. I feel more safe. Because I always been at home, so you see I was raised havin' the babies at home and my mother did, so I felt more safe that way.⁴¹³

When asked if she had been relieved to have had that last birth in the hospital, she replied that, it had been the most frightening, and that she agreed with her mother that the “old ways are usually the best.”⁴¹⁴ However, it was Marya's daughter, Joie who had expressed the desire for her own baby to have “modern medicine,” for his thrush, as described earlier. While Marya was glad for the “old-timey” remedies she had learned from her mother, Bernita, and her own home births “way out in the country,” her daughter showed a distinct shift in her perception of folk healing methods.⁴¹⁵ By this point, many of the women who had maintained the traditional practices had long since been retired by the health departments of the South.

African-American lay midwives were increasingly considered a “dying breed” of mostly elder women, who were frequently asked to discontinue their practices. In Mississippi, state officials came up with the idea of holding special retirement ceremonies for midwives during which they would be presented with badges and awards for their services rendered to the community. They were, according to officials, an effective method of forcing out some of the women they had grown tired of monitoring. Elderly midwives had long been considered unfit in the public discourse, however popular they were among childbearing women. The retirement

⁴¹³ Ibid.

⁴¹⁴ Ibid., 22.

⁴¹⁵ Ibid.

ceremony was a way for state officials to nudge them out of service for good. In a letter to Lucy Massey, the director of Public Health Nursing in Mississippi, Andrew Hedmeg, MD, of the Jackson County Health Department, wrote:

Another suggestion which I believe merits some thought was the idea of specifying a retirement age for midwives. As you well know, some of ours are rather antiquated, hard to control and have long outlived their usefulness, and an official statement might be of help in forcing their retirement.⁴¹⁶

In a letter to a physician, Lucy Massey suggested that the midwives would be more likely to go along with the retirement plan if they were presented with a badge. She added, “I think the midwives would like it and such a scheme might induce some of the older ones who should stop practicing to do so.”⁴¹⁷ The extent of the retirement plan and how willing elder midwives were to go along with it are unclear. What is clear, however, is that when they did choose to retire, they did their best to maintain their dignity, and the true nature of their services was reflected in the ceremonies.

Midwives’ retirement ceremonies reflected the spiritual nature of their work and the role of religion in their lives. They were held in churches, and had the same style and tone as a regular service. A ceremony held in May 1950 in Hinds County, Mississippi was opened by the president of the local midwife club, and included a scripture reading, recitation of the Lord’s Prayer by the attendees, and a health sermon offered by the minister. The midwife who was being retired received a gift of ten dollars from the congregation, and refreshments were served

⁴¹⁶ Andrew Hedmeg, MD, letter to Lucy Massey, September 8, 1947 (MDAH, Public Health Nursing Correspondence, Memoranda and Reports Documenting the History of Public Health Nursing [Principally Midwifery] in Mississippi, 1940–1950, 2 of 2, Loc 51:8416:11-18-1).

⁴¹⁷ Lucy Massey, Letter to Dr. Underwood, February 2, 1948 (MDAH, Public Health Nursing Correspondence, Memoranda and Reports Documenting the History of Public Health Nursing [Principally Midwifery] in Mississippi, 1940–1950, 2 of 2, Loc 51:8416:11-18-1).

following the ceremony.⁴¹⁸ The women were treated with honor and held in high esteem in their communities. The midwives made the ceremony their own, as they had done with all of the state-imposed regulations.

In Georgia, elder midwives were encouraged to step down when it was believed that they could no longer maintain a high level of care. When retired, midwives in this state received a badge and a small pension from the state, after taking an oath that they would no longer practice midwifery.⁴¹⁹ An elder and highly regarded midwife from Georgia was encouraged to step down by the public health nurse in her county. Ms. Jeanie resisted saying that, “The Lord ain’t viewed me to quit.”⁴²⁰ She was finally persuaded through the efforts of her community. A special church service was organized around a telling of the first chapter of Exodus and the service of this particular woman. Ms Jeanie relented by saying:

The Lord has this day viewed me to quit and step down off the Board and leave the work to them that’s abler in mind and body. And now if you got my badge handy, just pin it on me in the face of this congregation that knows I been passing faithful and never quit till the Lord knowed I can’t hardly get along, and He lifted all the burden He laid on me.⁴²¹

The intention of the state health department was to encourage the retirement of women who were no longer able to maintain the proper practices of cleanliness and discipline. There were, of course, other signs at this time that the lay midwife was increasingly being nudged out of her role as primary caregiver to childbearing women of the South. In reports from the late 1940s there is evidence that some new options were being explored in many communities. The annual report from Coahoma County, Mississippi reported that births attended by midwives had declined 38

⁴¹⁸ “Report to Health Department of Retirement Ceremony,” May 4, 1950 (MDAH, Public Health Nursing Correspondence, Memoranda and Reports Documenting the History of Public Health Nursing [Principally Midwifery] in Mississippi, 1940–1950, 2 of 2, Loc 51:8416:11-18-1).

⁴¹⁹ Marie Campbell, 89.

⁴²⁰ *Ibid.*, 91.

⁴²¹ *Ibid.*, 95.

percent over the past year, and that physician-attended deliveries of black women were more common.⁴²² The report stated that a section for African-American patients was being built in the new county hospital, which would include a maternity ward and delivery room, and that this would lead to even greater numbers of physician-assisted births. The ultimate goal of the health department was to have only occasional cases being attended by midwives.⁴²³ The nature of the community's response to the maternity ward is unclear, but the shift in numbers of physician-assisted births indicates that women were becoming more comfortable with changes in the childbirth experience.

Childbearing women chose to accept or reject hospital births according to their own standards. Slossfield Health Center was located in close proximity to Birmingham, Alabama's largest city. Founded in 1939, Slossfield was described as a "polyclinic which is like an outpatient department of a hospital with diagnostic and treatment facilities."⁴²⁴ African-American physicians received training at Slossfield in prenatal and postpartum care. The Health Center included a maternity service where physicians attended women during childbirth either at the center or in their homes. Patients were required to register at the clinic before the seventh month of pregnancy in order to be eligible for the service. Records from the clinic show that in 1940, 32 percent of the surrounding population received some form of maternity services at Slossfield.⁴²⁵ In a letter addressed to the Jefferson County Health Department in 1944, Eva F. Dodge, MD, states that "some of the Negro physicians in Mississippi are interested in a

⁴²² Coahoma County Department of Health, "Annual Report of Coahoma County Health Department," 1948, p. 35 (MDAH, Loc 51:8710:22-25-1:311-312).

⁴²³ Ibid.

⁴²⁴ "Slossfield Health Center Report of Health Services," 1940 (UAA, Folder 4.7).

⁴²⁵ Ibid., 9.

postgraduate course in obstetrics,” and asks whether the instruction offered at Slossfield was available to physicians from other states.⁴²⁶ The Slossfield center provided instruction and training to physicians who had an interest in obstetrics. It also provided an alternative to childbearing women in the area. It is unclear, however, whether the shift under way from midwife to physician-assisted birth led to reduced infant mortality rates in the area. A report by the Jefferson County Health Department in the 1940’s indicated that although the midwife practice of Birmingham and Jefferson County had been reduced to about 2%, with physicians delivering the majority of cases, maternal and neonatal mortality rates had continued to be high for the county and “particularly high” for the Slossfield area.⁴²⁷

Although the Slossfield Center and the black maternity ward in Coahoma County represent some change in how the Alabama communities approached maternity care for African-American women, they did not signal a widespread shift from home to hospital birth. In 1940, midwife-assisted, out-of-hospital births still accounted for an estimated 90 percent of births for Alabama’s nonwhite women. In 1960, 45 percent of Alabama’s nonwhite women were having out-of-hospital births. It was not until 1980 that the percentages for out-of-hospital births resembled those of white women in other parts of the country.⁴²⁸ The African-American midwives of Alabama and other Southern states, despite the intentions of most health departments, did not fade rapidly into nonexistence. Whenever there was a gap in service to childbearing women, they quickly filled it. In the mid-to-late 1950s, physicians in Alabama began to attend more

⁴²⁶ Letter to Dr. George Dennison from Eva F. Dodge, MD, May 3, 1944 (UAA, Folder 4.11).

⁴²⁷ Jefferson County Department of Health, “A Proposal to Provide Medical, Nursing, and Hospital Care for Maternity Patients and Children at Slossfield Health Center for Negroes in Jefferson County, Alabama,” (UAA, Folder 4.5).

⁴²⁸ John Houde, Joan Humphrey, Beverly W. Boyd, and Robert L. Goldenberg, “Out of Hospital Deliveries in Alabama, 1940–1980,” *Journal of the Medical Association of the State of Alabama* (August 1982), 21.

African-American women in home births. In 1950, for example, 57 percent of home births were attended by lay midwives, with the remaining being attended by physicians. By 1960, however, physicians retreated from providing this service, and the percentage of midwife-assisted births jumped to 80 percent of the out-of-hospital cases.⁴²⁹ This indicates that there were still enough active midwives available to meet the needs of the community, and that the childbearing women of Alabama maintained a trust in their services.

The shift from home to hospital birth among African American women of the South did not follow a smooth trajectory. There were bumps along the way. During the decades of the 1940's and 1950's transitional figures appeared which signaled a shift that was beginning to occur. Even when there was an acceptance of modern medicine, there often remain certain vestiges of the traditional system. For example this passage comes at the opening of a book on the experiences of a self-described "modern midwife."

Wearing nothing but a shiny coat of sweat, the young black woman stood upright on her hospital bed, stomping from the lumpy pillow to the foot rail and then back again. For the past fifteen minutes she's been running laps on top of her bed, towering four feet above me as I raced along the floor with my arms outstretched in the futile hope that I might catch her if she fell.⁴³⁰

In her first chapter titled, "You Have to Lie Down," Peggy Vincent, a California midwife who participated in the modern natural childbirth movement, described one of her earliest experiences with a woman in childbirth. The woman is referred to as "Zelda," and the incident takes place in the Duke University Hospital in 1962. In the chapter, Vincent describes the experience of attending to Zelda as a nursing school student, as one of her first discoveries of the power of childbirth. Vincent describes Zelda in detail. She was, "so skinny I could see the tendons in her

⁴²⁹ Ibid.

⁴³⁰ Peggy Vincent, *Baby Catcher: Chronicles of a Modern Midwife* (New York: Scribner, 2002), 17.

arms and the sharp angles of bones in her face. Even with her belly sticking in front, her hip bones jutting beneath the brown skin were easily visible.”⁴³¹ This vivid description of Zelda’s physical frame is a jarring. Vincent had been witness to several other births. But this one was different. “Zelda refused pain medication,” she writes. Zelda explains to Vincent how she had delivered her first two children. “They was delivered by my granny down in Tennessee, and I can tell you, I’m going back to Granny Vida if I have another one...Granny let me walk, see, yes, she let me walk and sing and dance my pains away.”⁴³² Eventually, Zelda was restrained and sedated by the hospital staff, and her baby was delivered in the lap of the doctor.

A tall nurse carried the bundled baby out the door, and I thought, Zelda doesn’t even know it’s a boy. I slipped my fingers into her loosely curled hand and held it as I watched another nurse jam a white sanitary pad between her dark and bloody thighs. When they stretched her legs out flat, her belly wrinkled like a deflated brown balloon and slumped between her angular hipbones.⁴³³

This disturbing scene is re-counted by Vincent as a way to describe her first realization that there were alternatives, to the medicalized model of childbirth. She goes on to become an instrumental member of the modern natural childbirth movement. But what happened to Zelda, and her “granny”? What happened to the traditional methods of childbirth, and to the African American women of the South who had not completely forgotten the teachings of their grandmothers? Their path to modernity was jagged, rough, and uncertain at times. The health care system of the South reflected, during these years, the overall intentions of exclusion and biases towards African American women. Despite this, black women continued to provide care

⁴³¹ Ibid.

⁴³² Ibid, 19.

⁴³³ Ibid, 23.

for themselves, for their relatives, neighbors, and friends. At times the care they provided did not meet the standards imposed by the health department. At other moments they were a great comfort to each other, and were more attentive to the needs of the mothers in their care than any other provider could have been. There was no one uniform set of practices among the African American midwives of the South. Personality, personal experience and preference all played a role in determining the type of care they would provide. There is more work to be done in order for us to fully understand the experiences of black women in medicine, healing, and childbirth. My hope is that the present study set us on the path towards a more complete understanding of these interrelated themes.

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