

CATCHIN' BABIES: AFRICAN AMERICAN MIDWIVES, MATERNITY CARE,
AND PUBLIC HEALTH DEBATES IN THE
JIM CROW SOUTH, 1920-1970

by

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Abstract

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Much of the scholarly research on African American midwifery in the Jim Crow South has been focused on the traditionally prestigious role of lay midwives, and the way in which these women were forced into obsolescence by the politically powerful medical profession. However, little has been written about the type of care they provided, or how midwifery and maternity care evolved under the increasing presence of local and federal health care structures. Using evidence from the nursing, medical, and public health journals of the era, as well as the personal memoirs of lay midwives, this study employs a micro/macro analysis to provide a new perspective on the changing childbirth experience of African American women during the mid-twentieth century. Moreover, this analysis illuminates valuable aspects of a maternity care model that were discarded in the name of progress, and yet might be rehabilitated to enhance modern maternal care.

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Chapter 1

Introduction

In 1985 the Eutaw, Alabama City Council gave the key to the city to its first African American recipient, seventy-nine-year-old Margaret Charles Smith, a lay midwife. May 2 designated as Margaret Charles Smith Day, has been celebrated in honor of her commitment and dedication to improving the healthcare of her community. Until the late 1970s when midwifery was declared illegal in many Southern states, lay midwives once numbering in the tens of thousands, provided maternity care to women who otherwise had none.¹ In 2009, at an event dedicated to the legendary Margaret Charles Smith, the *Birmingham Weekly* newspaper quoted Jennifer Crook Moore lamenting the fact that for many poor women access to maternity care was still desperately inadequate. She exclaimed, “ There are ten counties in the Black Belt, and ten of them have no hospital maternity services . . . it’s just baffling. And those are the areas where the midwives used to work.”² Moore’s point spoke to a wider truth than she implied. A deficiency in maternity care is not locally restricted to the Black Belt of Alabama, where statewide twenty-seven percent of non-white women have delayed or no pre-natal care. Moreover, a similar pattern exists across the country with the most poorly served women in southern states.³

¹ Susan L. Smith, *Sick and Tired of being Sick and Tired: Black Women’s Health Activism in America, 1890-1950*, (Philadelphia: University of Pennsylvania Press, 1995), 119.

² Jesse Chambers, “Screening of “Miss Margaret” Documentary in Eutaw,” *Birmingham Weekly*, May 1, 2009. Eutaw, Alabama is in Green County, one of the ten comprising the Black Belt.

³ “Deadly Delivery: The Maternity Health Care Crisis in the USA,” (Amnesty International Secretariat: London, 2008), 106-107.

The availability of maternal health care to poor, rural black women in the Jim Crow South changed considerably at a few landmark moments. With the passage of the Sheppard-Towner Act in 1921 government regulation of the most prominent form of maternal health care, midwifery, began. With civil rights legislation, black hospitals desegregated, and access to doctors widened. With the implementation of Medicaid later in the 1960s, further changes still occurred. Indeed the half-century between 1920 and 1970 reveals a very rapid transition from childbirth as a traditional, community-centered affair to a medicalized, hospital-based event. The history of medicine has historically been studied with the assumption that scientific progress, in this case the medicalization of childbirth, is linear, unidirectional, and always positive. Although it is foolish to deny the undoubted benefits of modern medicine, the “things-are-getting-better-all-the-time” approach must be recognized for its failings.⁴ As the *Birmingham Weekly* reported, many women in the South, particularly African American women, do not have ready access to maternity services.

Current national maternal and infant mortality statistics reflect the inadequacy of the system brought by twentieth-century “improvements.” Once again today, as was the case before Congress implemented Sheppard Towner, a large segment of the population is excluded from the current health care system. Today the American health care system consistently outspends others, and yet maintains unacceptably high maternal and infant mortality and morbidity rates when compared to similar post-industrial economies. More significantly, black women in America are more than four times as likely to die from pregnancy related complications than are white women.⁵ At the turn of the twenty-first century only 64 percent of African American women received any type of pre-natal care.

⁴ Mary Lindemann, *Medicine and Society in Early Modern Europe*, 2nd ed. (Cambridge University Press, 2012), 3.

⁵ “Deadly Delivery: The Maternity Health Care Crisis in the USA,” 1.

Of the remaining 36 percent, those who had no pre-natal care were mostly poor, young, unmarried, and rural.⁶

This study of maternal health care in the past includes, ironically, a solution for the future, a somewhat unusual intervention for an historical study. One obstetrician interviewed in 2008 sums up the direction in which maternal health care should go when she argues, “What works isn’t flashy, not expensive, but it’s human intensive.”⁷ In fact, guidance for improving maternal health care and access today may be gained by looking back to the post Sheppard-Towner era where service was tailored to the community it served, it was embedded at the local level, made full use of the community’s assets and valued its cultural identity. Dr. Collins Airhihenbuwa, a bio-behavioral health specialist, has promoted a cultural-empowerment model of health care as a way to address the problems facing the African American communities presently being neglected by the health care system. This model takes into consideration what he terms micro and macro factors of care, both of which, he argues, are necessary for acceptable and effective health care provision.⁸ Airhihenbuwa’s model defines the micro elements of health as those found at the grassroots level such as community and individual knowledge of health, how health is understood, interpreted and transmitted, how religion and spirituality relate to health, illness, and treatment. Macro components of health care are found at the state and federal level and include hospitals, medical professionals and scientific knowledge (as opposed to micro level empirical knowledge). Macro level healthcare brings with it state and federal structures and the associated hierarchy, institutional

⁶ Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care*, (New York: Continuum, 1998), 116.

⁷ Dr. Heidi Rinehart quoted in “Deadly Delivery: The Maternity Health Care Crisis in the USA,” (Amnesty International Secretariat: London, 2010), 92.

⁸ Townes, 152.

racism and the presumed superiority of western modern medicine. This categorization is essential for understanding what elements of maternal health care have altered over the last century for African American women.

Although Airhihenbuwa's connection of culture to health is not new, he does point out that not all culturally appropriate health initiatives are successful. He rejects models that create a tendency towards victim-blaming, or ones of self-empowerment that focus too heavily on the individual being responsible for health, and promotes the cultural-empowerment model as superior for African American health because of its focus on the community. He argues that African Americans "have a rich heritage of surviving and sometimes thriving in hostile contexts" and much of their resilience is grounded in the community and the church.⁹

Beginning in the 1940s, collaboration between licensed lay midwives and public health nurses and nurse-midwives (the public face of state boards of health) resulted in achieving a balance between the micro and macro factors of healthcare; community services supported by hospital facilities, vocational caring improved by professional standards. It was a model of care that took into consideration the health beliefs and cultural attitudes of individuals at a community level, or a micro level, while simultaneously functioning at an increasingly state or national level, a macro level. Since maternity care in the South, in fact all aspects of medicine irrespective of geography, were embedded within a larger framework of society, the pressures of systemic racism and circumscribed gender roles prevented the long-term existence of this model in this region. However, studying the trajectory of maternity care using this

⁹ Collins O. Airhihenbuwa and Leandris Liburd, "Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender, and Power," *Education and Behavior*, Vol. 33, No. 4 (August, 2006), 495.

micro-macro approach as an analytical structure, reveals the strengths and weaknesses of care provided across a time period during which micro elements of care were superseded by the macro.

This study is divided into three main parts, the focus of each section being on the style of care rather than on chronology since there is much overlap in the narrative. Simplistically put, the chapters chart a shift from a predominance of micro level care, through a micro/macro blend, to an emphasis on macro level care. Chapter One focuses on the role of traditional lay midwives and how they adapted to the increasing presence of local, state, and federal public health mandates beginning in the early 1920s. Their prestigious position in the community afforded them great influence and although their efficacy was grounded in micro level elements of care, they were limited in their inability to access macro level care. Chapter Two explores the issues and debate surrounding the introduction of certified nurse-midwives to the region in the 1940s. This chapter discusses the attempt to buttress micro level care with the modern, scientific macro components so crucial to effective maternity care. I broadly focus on the clash of philosophies of micro, community based care and macro, scientific, western model of medical care, and specifically highlight the difficulties faced by African American nurses and nurse-midwives as they negotiated a professional arena plagued by systemic racism. Chapter Three offers a historical backdrop to the changing face of hospital care and medical access across the South between 1920 and 1970, and presents the specific problems encountered by African American women seeking maternity care in a system dominated by macro level care. In a brief epilogue I attempt to make connections to contemporary problems using the historical perspective developed in the previous three chapters.

There exists a sizable body of scholarly work on African American lay midwives (those who were not professionally educated), much of which focuses on the demise of

the traditional midwife. The scholarship generally coincides with the increasing interest in a less interventionist childbirth demanded by white middle-class women dissatisfied with their experience in the last decades of the twentieth century. Historical, sociological, and anthropological studies tend to highlight the unusual degree of respect and influence held by the lay midwives in an era when poor, rural, African American women were denied any and all privilege by society at large. The historiography that does exist is overly simplified, conceptualizing midwifery as a black versus white issue, incorrectly assuming all African American midwives were lay-midwives, who were eradicated by “superior” white healthcare professionals. Documented as a lost tradition, the shift to medicalized childbirth represented the march of progress.

The available primary sources for black lay midwifery are a handful of memoirs written by women at the end of their lives in the 1980s and early 1990s. Four such sources are used heavily in this study are the memoirs of Onnie Lee Logan, Margaret Charles Smith, Claudine Curry Smith, and Gladys Milton. The publication dates of these coincide with the rise of renewed interest in a less interventionist childbirth by white, middle-class women.

However, the professionally trained and educated African American nurse-midwives have been given little attention, perhaps because of the dearth of primary sources available. The self-assessment publication issued by the Maternity Center Association in 1955 provides a valuable history of the early years of certified nurse-midwifery in America, and also introduces the concept in the southern states. More specifically, the 1945 bulletin for the Tuskegee School of Nurse-Midwifery gives an overview of the entrance requirements and curriculum for the students. Unfortunately, beyond this few primary sources are available. This is largely due to the fact that the Tuskegee Institute did not formally embrace the school of nurse-midwifery as part of the

university, and so neglected to preserve its history in the archives. Much of the 1940s documentation from Macon County Health Department was destroyed by fire leaving little primary evidence of the work of the students and graduates in the field. Lucinda Canty in her master's of nursing thesis listed biographical information on ten of the thirty-one graduates that is helpful in establishing a picture of who these women were.

The bulk of other primary sources used are from medical and nursing journals, on the pages of which the debates were fought. It is through these voices, the voices of both the professionals and the lay practitioners, that the childbirth experience of African American women in the Jim Crow South can be interpreted.

A word about terminology: Along with the concepts of "micro" and "macro" discussed above, this study refers to several different gradations of midwife occupations. For clarity, it is important to stress the difference between lay midwives and nurse-midwives. Certified nurse-midwives were (and continue to be) registered nurses with postgraduate education and clinical training specifically in the care of women throughout pregnancy, labor, and the post-natal period. Lay midwives, with no prior training gained their knowledge by observation, and their skills developed by experience under an apprenticeship. During this time period many would become licensed by the state, however this did not raise them to the status of certified nurse-midwives. Lay midwives in some sources are also referred to as granny midwives, but during this time period not all midwives were elderly, so "lay midwife" seems to be a better term and will be used throughout.

The history of maternity care is particularly valuable for those interested in the role of gender and race in shaping American motherhood. The physiology of pregnancy and childbirth is unchanging and experienced by the majority of women, therefore exposing more readily shifting attitudes and accepted societal norms regarding childbirth.

Adequate and consistent pre-natal care remains the key to lowering maternal and infant mortality. Somewhere along the trajectory of maternal health care, where community-centered, holistic care was provided by effective and competent professionals working within a larger health care system was an opportunity to optimally meet the needs of a population bereft of significant healthcare services. This study provides an opportunity to explore an aspect of the history of medicine in a new light, from a perspective that exposes the value of community centered, culturally appropriate, holistic care once discarded as archaic and “backward”, that may actually have solved health care needs much better than the wholesale regulation that came after it would suggest. Clearly, I am ill equipped to propose a modern maternity care policy and that is certainly not my intention, however, a secondary advantage of this study may come from what the past suggests for our current healthcare dilemmas.

Chapter 2

Motherwit: African American Lay Midwifery, 1920-1950

The political, economic, and social conditions of the South created a unique place for African American lay midwives to develop a model of maternity care and associated childbirth culture that served their patients fairly well. The isolation and exclusion of African American communities, particularly in rural areas, allowed a rich tradition to persist. As the trend towards medicalization of childbirth proceeded in the urbanizing North, maternity care in the South followed a different trajectory, lagging behind that in the North. In an era of social scientific notions of progress it was inevitable that a government intervention would be considered. And so the same story that includes the rich development of a lay midwifery culture also illustrates how that culture could be adapted to new circumstances.

It seems odd that a group of poor, barely educated African American women, entirely powerless outside of their marginalized communities, would be the subject of vociferous debate in the medical world, but so lay midwives were during the early decades of the twentieth century. Though maligned as “evil” and believed to undermine a physician’s authority and right to economic security, these women were simply answering a vocational calling to serve their communities as generations of others had done before them. In the face of overwhelming poverty, deprivation, and systemic racial discrimination, African American lay midwives filled a crucial void in the provision of maternity care across the South. Viewed within the larger trajectory of maternity care as it progressed through the mid-point of the twentieth century, lay midwifery was of great value. When evaluated in terms of the micro-macro components of care, lay midwifery appears lacking on the macro level, given that their access to scientific knowledge, medical expertise, and modern facilities was severely limited. But the micro aspects of

care were entirely fulfilled by these non-professional health care providers who were embedded in the community they served. Culturally specific motifs such as the acceptance of the authoritative knowledge of lay midwives, and the granting of communal authority to women without formal bureaucratic powers were essential to their success. Nevertheless, when viewed through the Eurocentric, patriarchic lens of a medical profession that placed scientific medical knowledge (macro level) above all other, they were dismissed as useless and obsolete. Added to this was a bias grounded in the racial stereotyping of the Jim Crow South.

Lay midwives first became a concern to state and federal agencies during the early decades of the twentieth century, marking the start of this study's trajectory. A government study published by the Children's Bureau in 1917 reported an intolerably high national maternal mortality rate. It declared that the U.S., when compared to sixteen other industrial countries, ranked in fourteenth place with only Spain and Belgium recording higher maternal mortality. Moreover, the study went on to reveal that the mortality rate for black women was double that of white women and that if accurate statistics from southern states were available, the disparity between the two groups would be magnified. This marked difference clearly indicated "without a doubt a very great difference in standards of care at childbirth in these two groups".¹⁰ For most in the

¹⁰ Grace L. Meigs, *Maternal Mortality from All Conditions Connected with Childbirth in the United States and Certain Other Countries*, United States Department of Labor, Children's Bureau Publication, No. 19 (Washington, D.C.: Government Printing Office, 1917), in *The American Midwife Debate: A Sourcebook on its Modern Origins*, Ed. Judy Barrett Litoff (New York: Greenwood Press, 1986), 61. 15.2 deaths per 100,000 in the white population, 26.1 deaths per 100,000 in black population. When maternal mortality compared in 16 countries US ranked 14th, with Spain and Belgium in 15th and 16th place. Norway and Sweden had lowest rates, England, Ireland, Japan had decreasing rates.

medical profession, the responsibility for this disparity of care fell squarely on the shoulders of lay midwives and more specifically, with African American lay midwives who were in their largest numbers in the southern states serving the needs of the black population there.

By the 1920s most northern women, irrespective of social class, were experiencing a hospital birth. Lay midwives in the North were almost entirely of European descent, and were soon out of a job. Having defined midwifery to be a “relic of barbarism”, American physicians actively pressed forward with the promotion of scientific childbirth, placing what had always been perceived as a fundamentally natural physiological event securely into the realm of pathology requiring medical expertise. New concepts of asepsis, analgesia, and sedation during labor coincided with the professionalization of medicine creating an atmosphere of expanding scientific horizons for the new medical specialty of obstetrics. In order to attract talented physicians to the field clinical experience and experimentation was offered in the growing number of hospitals that provided maternity care in impoverished urban neighborhoods. Here, poor women experienced an actively managed labor consisting of heavy sedation, the elimination of the second stage of labor by use of forceps, and the manual extraction of the placenta. Middle- and upper-class women perceived the medically managed, hospital birth to be a symbol of modernity and progress reflecting the trend towards full acceptance of medical authority and knowledge.¹¹

¹¹ Diana Scully, “From Natural to Surgical Event” in *The American Way of Birth*, ed. Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 47-59; Margarete Sandelowski, *Pain, Pleasure, and American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960* (Westport: Greenwood Press, 1984), 3-10.

Social and cultural changes only peripherally related to childbirth solidified the shift to medicalized hospital birth. Access to mass transportation, automobile ownership and availability of contraception all contributed to the growing acceptance of modern methods and technology. The assimilation process and the restriction on immigration to northern urban areas led women to look upon physician-managed births as a mark of distinction connecting them with American womanhood.¹² In the mid-1920s approximately 50 percent of all births in large northern cities took place in hospital. However, physician-assisted hospital birth did not initially lower maternal mortality rates. In fact the national maternal death rate in 1932 stood at 63 deaths per 10,000, up from the 1915 rate of 60 per 10,000. Significantly, the mortality rate in urban areas, where hospital birth had become common, was higher than the national average. It was not until the introduction of antibiotics in the late 1930s and 1940s that maternal mortality began to decline rapidly.¹³

Comparative figures for the southern states are difficult to accurately assess largely due to the incomplete, often nonexistent, records of vital statistics. Suffice it to say, the almost total neglect of the health needs of the African American population in the South resulted in a very different trajectory of maternity care. In the socially, politically, and economically deprived population there existed an indescribable level of chronic ill health, the depth of which was not fully realized until federal government physicians

¹² Nancy Schrom Dye, "The Medicalization of Birth" in *The American Way of Birth*, ed. Pamela S. Eakins (Philadelphia: Temple university Press, 1986); *The American Midwife Debate: A Sourcebook on its Modern Origins*, Ed. Judy Barrett Litoff (New York: Greenwood Press, 1986),10.

¹³ Dye, 41, 42.

assessed the region in the 1960s.¹⁴ African Americans of the rural South had little access to a hospital or a physician. Lay midwife, Margaret Charles Smith from Eutaw, Alabama, routinely traveled two hundred miles to Tuskegee's Andrew Memorial Hospital in the event of one of her patients requiring emergency treatment; it was the closest hospital that would admit black patients.¹⁵ Until as late as 1947 there were no hospital beds for black women in Arkansas except for twenty-three beds at the University Hospital of Little Rock.¹⁶ Racial barriers meant that African American doctors were absent in rural areas and many white doctors would not attend black women out of sheer disregard for black health, or because of a real or imagined inability to pay for treatment.

With no alternative poor women in the South relied on lay midwives for assistance in childbirth. The enduring institution of midwifery was fundamental to the cultural and social aspects of childbirth, and the elevated position held by the midwife was central in the formation of community networks and relationships. Midwives, because of the inheritance of the role from an older female relative, were seen as transmitters of culture and repositories of folklore. Revered as models of wisdom and strength, they represented a high point of authority and prestige within the community. Midwives relied on a deep spirituality to guide their actions, and many reported having experienced a supernatural "calling" that validated their acceptance of the responsibilities and obligations that were integral to their position. This commitment to serve and the continuity across generations is reflected in the appellation "granny midwife". Many lay

¹⁴ James C. Cobb, *The Most Southern Place on Earth: The Mississippi Delta and the Roots of Regional Identity* (Oxford: Oxford University Press, 1992), 264-265

¹⁵ Margaret Charles Smith, *Listen to Me Good: The Life Story of an Alabama Midwife*, (Columbus: Ohio State University Press, 1996), 86.

¹⁶ Pegge L. Bell, "'Making Do' with the Midwife: Arkansas's Maimie O. Hale in the 1940s," *Nursing History Review I* (1993), 156.

midwives had grown children and were likely to be grandmothers, but at a deeper level the midwives became the embodiment of the social networks of the community. The midwife became the “granny” of all the babies she delivered. Onnie Lee Logan remembers people saying, “That yo’ granny. That’s yo’ grannymother. She delivered you. She’s the one that first put her hands on you. She’s the one that made you cry, got the breath in you.”¹⁷ Children and adults often visited their “granny” midwife on birthdays or important life milestones. Claudine Curry Smith, a midwife in Virginia was filled with joy when she recalled delivering two generations in a family. To see a child that she delivered reach maturity, and then attend her in childbirth was one of her greatest pleasures.¹⁸

Lay midwives, then, were linked to the past through their apprenticeship with older women, and use of traditional techniques, but also connected to the future through the relationships they maintained with the individuals they delivered. It has been also been argued that their role as transmitters of culture may have played a part in establishing an order that rose above the turmoil and uncertainty of everyday life.¹⁹ The cultural stability offered by the midwife was reinforced in the matriarchal structured society that was prevalent in the Jim Crow South. The four lay midwives whose memoirs form the platform of this study all speak with great reverence and love for the maternal figures in their lives, be it their mother, grandmother, or aunt. It was to her that they

¹⁷ Onnie Lee Logan as told to Katherine Clark, *Motherwit: An Alabama Midwife’s Story* (New York: E. P. Dutton, 1989), 50.

¹⁸ Claudine Curry Smith and Mildred h. B. Roberson, *May Bag was Always Packed: The Life and Times of a Virginia Midwife* (Bloomington, Indiana: 1st Books Library, 2003), 122.

¹⁹ Sheila P. Davis and Cora Ingram, “Empowered Caretakers; A Historical Perspective on the Roles of Granny Midwives in Rural Alabama”, in *Wings of Gauze: Women of Color and the Experience of Health and Illness*, ed. Barbara Blair and Susan E. Cayleff (Detroit: Wayne State University Press, 1993), 195.

looked to for strength and guidance in life and practice even as elderly women, as they continued to live by the example set by their matriarch.

Fundamental to the work of a midwife was her religious “calling”. Despite traditional knowledge and skill, midwives relied on their spirituality to guide their actions; in fact, prayer and spirituals were integral features of childbirth. Onnie Lee Logan described her God-given wisdom as “motherwit” and during her many years of practice she always ‘kep’ God in front.”²⁰ Other midwives claimed to have “some kind of feeling knowing they are always blessed” or that they “take the Lord into their insides” before they act.²¹ Elizabeth Singleton, in recounting her experience remarked, “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 me take care of you.”²² Onnie Lee Logan, when faced with having to resuscitate a newborn, recalled that she “pitched out on what God told [her] to do, and forgot about books and other people.”²³ With confidence in her God-given “motherwit”, having never been taught cardiopulmonary resuscitation, she performed gentle compression with artificial respiration until the baby cried and was able to sustain its respiration.²⁴

Several midwives were elevated to the status of “Mother of the Church”, a revered position of spiritual wisdom at a time when in many churches spiritual leadership was patriarchal.²⁵ Childbirth was recognized as a dangerous event in a woman’s life and the perception of doing “God’s work” necessitated an element of fatalism on the part of

²⁰ Logan, 89.

²¹ Margaret Charles Smith, 85.

²² Judy Barrett Litoff, *American Midwives* (Connecticut: Greenwood Press, 1978), 32.

²³ Logan, 88.

²⁴ Ibid, 89.

²⁵ Davis, 192.

the midwife, the will of God being served in death as well as in life.²⁶ This was just one aspect of the African American lay midwife's philosophy that was in direct opposition to the medical establishment's absolute acknowledgement of the preeminence of scientific methods.

A midwife's pivotal position in the community as a transmitter of culture, folklore, and spirituality was only one facet of her empowerment. Midwives had not the advantage of formal education and yet they had an innate resourcefulness or in Onnie Lee Logan's words, an ability to "use whatcha got."²⁷ Midwives saw themselves as "poor people who missed an opportunity to pursue an education", but midwifery allowed them to put their "big minds to work."²⁸ Margaret Smith was described as someone who could "make a way out of no way."²⁹ Complex decision-making combined with compassionate caring allowed midwives to function as autonomous, independent practitioners and they met few problems they could not overcome with the help of their community.

A common feature of the lives of the four midwives on whom there exists documentation is that their families were not quite as economically vulnerable as most in their communities. Since midwifery did not offer any financial advantage as midwives were rarely paid for their services, it can be assumed that the character traits exhibited by lay midwives were shared by other family members and applied to all aspects of their lives. Onnie Lee Logan's father owned land, farmed and had a carpentry business making funeral caskets for black and white customers. She said, "we never had to sharecrop for nobody.....but we stayed humble." Her mother taught her to "stay down,

²⁶ Molly Dougherty, "Southern Midwives as Spiritual Specialists," *Women in Ritual and Symbolic Roles*, ed. Judith Hoch-Smith and Anita Spring (New York: Plenum Press, 1978), 153.

²⁷ Logan, 68.

²⁸ Margaret Charles Smith, 63.

²⁹ Ibid, 88.

stay lil, stay humble, and serve God. That's where yo' blessin's come from."³⁰ That is not to say that Mrs. Logan's life was not one of hard physical work and hardship; it was, but she was painfully aware of the comparison between herself and poorer members of her community who were trapped in a desperate cycle of poverty and depravation. Margaret Charles Smith, Claudine Curry Smith and Gladys Milton all share stories providing evidence of their families' subtle advantage and good reputation within the community. Gladys Milton's aunt and lay midwife, Aunt Mag was accused of "trying to be white" but always retaliated by saying "you don't have to be rich to be clean and neat."³¹ African American lay midwives of the South were monetarily poor by any measure and lived under the devastating restrictions enforced by Jim Crow, but their elevated position granted them an unusual degree of influence in their communities, something they used to foster positive change.

But by the early 1920s, a significant change was underway. Conclusions from government studies identified three chief causes for the poor maternal mortality figures: general ignorance of the dangers associated with childbirth, the need for skilled care and proper hygiene, and poor access to adequate obstetric care.³² In response, Progressive Era proponents for improvements in maternal and child health steered through Congress the Sheppard-Towner Maternity and Infancy Protection Act in 1921. This law provided grants to states in order for them to meet the health needs of expectant mothers and newborns, the states being required to match federal dollars.

The protracted existence of midwifery in the South provided a unique opportunity for poor African American women to interface with state and local government and

³⁰ Logan, 11-21.

³¹ Wendy Bovard and Gladys Milton, *Why Not me? The Story of Gladys Milton, Midwife* (Summertown, TN: The Book Publishing Company, 1993), 23.

³² Meigs, 63.

drastically improve maternity care in their communities. Since midwifery was accepted as a necessary, albeit temporary measure in the South, primary among the goals of state departments of health was the need to license every midwife, standardize the care, and train her in rudimentary techniques of hygiene and asepsis. Reflecting the racist attitudes of the era, many state officials were dubious of intellectual capacity of African American women. In North Carolina, the medical officer of the Robeson County Health Department observed that the typical midwife in the rural South is “far below the European midwife in intelligence and no training under the sun could make her a competent obstetric attendant.”³³ In fact, the establishment’s attempt to legislate midwifery practice with the goal of eradication led to the creation of an unexpected cadre of African American health workers.³⁴ From the outset, midwives actively engaged in the changes brought about by Sheppard-Towner. Many states initiated a county-level program of classes for midwives that served three purposes: to inform the midwives of the “new laws” that would govern their practice in the future, to teach techniques of asepsis and personal cleanliness, and to monitor and license compliant practitioners on an annual basis. Department of Health officials generally observed and recorded a positive response from the midwives. They were eager to learn and regularly attended the compulsory classes despite many having to walk miles to the designated meeting places. Early in the training program offered at the Andrew Memorial Hospital in Tuskegee, the instructor Dr. Kenney observed: “It was interesting to see these women, some in their seventies, many of whom had never attended a day of school in the lives, come back and forth daily for their instruction. They

³³ E. R. Hardin, “The Midwife Problem,” *Southern Medical Journal*, 18 (May, 1925), 347-350 in *The American Midwife Debate: A Sourcebook on its Modern Origins*, Ed. Judy Barrett Litoff (New York: Greenwood Press, 1986), 148.

³⁴ Susan L. Smith, *Sick and Tired of Being Sick and Tired* (Philadelphia: University of Pennsylvania Press, 1995), 118.

were very enthusiastic over the work given them.”³⁵ Dr. James Ferguson attended a Midwives Club in Mississippi and reported a meeting with a “business-like atmosphere” being presided over by an efficient midwife leader and club secretary.³⁶ He credited the midwives with providing an improved level of maternity care just as supervisor Lois Trabert of Mississippi’s Bureau of Child welfare predicted in 1923 when she proclaimed; “I firmly believe that when we do get these midwives properly trained, in as far as that is possible, they will do better and cleaner work than the average country doctor.”³⁷

In some states Sheppard-Towner funds were allocated to surveying the midwifery “situation”. In 1924, Katherine Hagquist, supervisor of midwifery control measures, was assigned the task of assessing midwives in Texas. Hagquist, a white registered nurse, fell victim, as did many of her colleagues, to the pervasive cultural superiority and racial stereotyping that fed the perception of midwives being dangerous and incompetent. She described them as being “illiterate, usually dirty and in rags, gesticulating, often not able to talk or understand the English language, superstitious and suspicious” and concluded that their cultural practices surrounding childbirth was “seldom, if ever, in accord with modern science.”³⁸ However, Hagquist acknowledged that the midwives were, “almost without exception eager to attend classes of instruction and one could see a decided change in their personal appearance after having attended a few lectures and demonstrations.” The training programs with a strong emphasis on hygiene, were initially recorded a success when, like a butterfly emerging from a cocoon,

³⁵ Margaret Charles Smith, 65.

³⁶ James H. Ferguson, “Mississippi Midwives,” *Journal of the History of Medicine*, (Winter, 1950), 89.

³⁷ Susan L. Smith, 124.

³⁸ Texas State Board of Health, Bureau of Child Hygiene, “Report on the Midwifery Survey in Texas” in *The American Midwife Debate: A Sourcebook on its Modern Origins*, Ed. Judy Barrett Litoff (New York: Greenwood Press, 1986), 69.

the midwives were transformed from a “disorderly and dirty group of tobacco-chewing women” into a well-behaved class of pseudo-nurses wearing starched white aprons; they were cleansed of the negativity of their race and gender.³⁹

Clearly, African American lay midwives were ideally positioned to significantly raise the standard of maternity care. Their acceptance of their pivotal role in the community together with an eagerness to expand their knowledge base suggests that the midwives were well aware of the potential for positive change. Midwife training classes and pre-natal clinics became the nexus for micro and macro components of care. The pre-natal clinic visit provided a link to medical expertise, a dimension of macro-level of health care provision not previously available to poor women. Lay midwives were instrumental in persuading women to access this level of care. The training classes functioned as a bridging vehicle through which elements of scientific care could be disseminated to lay providers. Unlike the situation currently experienced by many poor rural women who do not receive adequate pre-natal care, lay midwives were fundamentally suited to providing “hands-on, boots on the ground” micro-level maternity care.

The midwives’ ability to “use watcha got” was quickly enhanced by the science-based knowledge imparted during training sessions⁴⁰. While some midwives had already made the connection between maternal wellbeing and cleanliness, all now adopted the dictates of the “new law” concerning hygiene. They were receptive to ideas that provided a better environment for themselves and the women they served. Because the midwives were fully embedded in their culture they saw immediately where and how improvements

³⁹ Molly Ladd-Taylor, “Grannies and Spinsters: Midwife Education under the Sheppard-Towner Act,” *Journal of Social History*, Vol 22, No. 2, (Winter, 1988), 264.

⁴⁰ Logan, 68.

could be made. Most women delivered on quilts that the midwives later had to wash and sterilize, but after some basic instruction in class, midwives refined techniques to make disposable pads and sanitary towels from newspaper. The midwife's manual emphasized the importance of preparation to ensure a clean environment at delivery is maintained and gives instructions on how to make them.⁴¹ Onnie Lee Logan used the activity of making and sterilizing the pads to get to know a mother during the pregnancy, developing a deeper, trusting relationship with her as well as ensuring that practical matters were addressed before delivery. She would "go and visit 'em. Talk with 'em. Look at the bed. See how the bed's set up cause [she] cain't work left handed. You have all that in front so when you got there you didn't have to start makin' preparations for that."⁴²

In the new context brought by Sheppard-Towner, the lay midwives' place in the heart of the community provided them with the opportunity to teach through home demonstration. The necessity of a clean, well-prepared environment for delivery was reinforced when midwives set up a model room in their home, opening it up for public viewing, sometimes receiving up to one hundred visitors. In 1934, 1300 lay midwives sent in reports of their demonstration rooms to the Mississippi Board of Health. As testament to midwife Matilda Holt Mitchell's resourcefulness, one visitor was inspired by what could be accomplished with so little. The visitor observed that with few resources, "old ideas and methods have been relegated and replaced by the modern, scientific and

⁴¹ Virginia State Department of Health, *Midwife's Manual*, 15 in Claudine Curry Smith, 159. The manual gives instructions on how to make padding for the bed and perineal pads. It also instructs midwives to sterilize a package of dressings in a slow oven. A potato should be placed in the oven and the dressings not presumed to be sterile until the potato is cooked.

⁴² Logan, 137.

streamlined ideas and methods.”⁴³ Their embeddedness in the local community enabled lay midwives to effectively teach principles of hygiene and preparedness to a greater number of women in a non-threatening environment.

Many families lived in inescapable poverty and had not the means to be adequately prepared for a new baby. Lay midwives took it upon themselves to teach women how to make do with what was available in terms of having a clean household and good personal hygiene. Onnie Lee Logan lamented the fact that poor black people had never been taught personal hygiene and she felt that “copycattin” was the best way to proceed. She understood that once one household was neat and clean, other families would follow suit. At more humble homes she would personally supervise the cleaning, gently teaching and advising. As one midwife said: “Oh Lord, I had a white uniform and when I come home, I looked like I’d been up the chimney and slid down.”⁴⁴ The lay midwives took their own sheets to a delivery if the mother was not thought to be able to create a clean environment in which to deliver, as well as soap, baby clothes, and food if needed.⁴⁵ Mrs. Curry remembered the community support she experienced recalling, “You know everybody was neighborly back then. If something happened, everybody fell right in to help you. That’s what made it nice, in all my deliveries I’ve ever been on.”⁴⁶ This familiarity with the families they served and the collective philosophy of self-help allowed the midwives to better meet the individual needs of the mother.

One of the most important elements in understanding the micro-level benefits of the new lay midwives system under Sheppard-Towner is the impressionistic evidence

⁴³ Susan L. Smith, 145-146.

⁴⁴ Davis, 195.

⁴⁵ Logan, 93; Claudine Curry Smith, 56; Margaret Charles Smith, 88; Milton, 47.

⁴⁶ Claudine Curry Smith, 66.

that the rewards spread beyond delivering healthy babies. Without the local knowledge, many women and children would have remained beyond the reach of the limited county or state assistance. When she came across cases of extreme poverty, Mrs. Logan quickly reported the emergency to the board of health. She would also have no hesitation in reporting negligent or abusive parenting if she suspected it to be the case.⁴⁷

Local social networks enabled lay midwives to be aware of new pregnancies and as state law dictated that a woman have a medical release to have a midwife delivery, they were effective in ensuring women had some level of medical care during their pregnancy.⁴⁸ Adequate pre-natal care had long been identified as the single most important factor in lowering maternal mortality rates and for the first time, with lay midwives as their advocates, poor black women had increased access to macro level care. Beyond better access to care, it was in the interest of the midwife to encourage a woman to attend clinic as her license to practice could be revoked if she delivered a woman who did not have documentation from a doctor. This permission slip also served as a written commitment from the doctor that he would support the midwife in the event of an obstetric emergency.⁴⁹

Seeing the midwives' familiar friendly faces in at the pre-natal clinics was reassuring to the women, many of whom were suspicious and distrustful of white physicians and local government. Margaret Charles Smith worked at three local clinics for twenty-eight years assisting the doctors and helping to allay any anxiety associated with the transition into the unfamiliar world of modern medicine. In a public health department educational film, midwife Mary Coley is seen accompanying a patient to a clinic

⁴⁷ Logan, 98.

⁴⁸ Ferguson, 89

⁴⁹ Claudine Curry Smith, 60.

appointment to simply offer emotional support as a female relative might.⁵⁰ The limited resources of most women accepted, the lay midwives taught women how to improve their diet, abstain from alcohol and tobacco, and rest when able in order to maintain their health throughout pregnancy. Since the women they served wanted a midwife delivery, the lay midwives were able to use the maintenance of good health as leverage. Onnie Lee Logan told her patients that “early visits to their physicians is better because there is probably a lot a work that need to be done befo’ it’s time to have the baby. It may take havin’ to build up a lil blood. You need a lot of counselin befo’ with yo’ vitamins and all that. If they get their visits done early it will he’p em to have a nice no’mal delivery.”⁵¹ The accepted cultural authority of the midwives and the consistency of their presence in the community, both micro factors not associated with physician- led care, made them extremely influential in the pre-natal education of women.

The micro-level care provided by lay midwives met the unique needs and demands of the women they served, demands shaped by a quite different past than their white sisters. These culturally specific aspects overlooked in the larger, medically driven macro-level care are crucial elements in providing effective health care. Childbirth customs of poor rural African American women in the Jim Crow South were not rooted in the western scientific tradition as presumed by white doctors and nurses, but rather they reflected the collective history of black people in America. West African traditions were syncretized with Native American and local customs, and herbal remedies and treatments were adapted to local flora. Although some treatments clearly conflicted with conventional medical wisdom, some folk practices employed by midwives were compatible with scientific theory. For example in a 1926 monograph, *Folk beliefs of the*

⁵⁰ George C. Stoney, *All my Babies: A Midwife’s own Story*, Film. George C. Stoney, 1953.

⁵¹ Logan, 136.

Southern Negro, Newbell Niles Puckett observed that, “almost everywhere the linen bandage used during childbirth must be scorched before applying, a practice with some distinct sanitary advantages.” Preparations containing spiderwebs, soot, and cherry tree bark -- all natural coagulants -- were used to treat hemorrhage.⁵² Philosophies of healing identified in antebellum slave medicine emphasized psychological, social, and spiritual components rather than the physiology-based medicine commonly used by white doctors, and these motifs are evident in the care given by lay midwives.⁵³

For enslaved women, reproduction was a profit-maker for their owner; every year from 1750 until emancipation one of every five black women between the ages of fifteen and forty-four, gave birth.⁵⁴ Yet, slave owners neither withheld a pregnant woman from hard, physical work, nor ensured she received care from a doctor. When viewed through this cultural lens, it is unsurprising that later generations of African American women would not see the necessity of a medical examination during pregnancy, or immediately accept childbirth as a pathological process. All women continued work, if they had work, until they went into labor. Some women only just managed to get to their cabins from the cotton field in time to make a pallet on the floor to deliver their own child.⁵⁵ Margaret Charles Smith delivered her second child herself without assistance, remembering she had “the good Lord” to help her.⁵⁶ Onnie Lee Logan also reinforces the perceived normality of labor. She said, “Childbirth is not a sickness – God gonna take care of that.....I declare a woman gonna have a baby if she out there in the middle of the street.

⁵² Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954* (Athens, University of Georgia Press, 2011), 83.

⁵³ Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (Anchor Books: New York, 2006), 48.

⁵⁴ *Ibid*, 45.

⁵⁵ Margaret Charles Smith, 35.

⁵⁶ *Ibid*, 49.

She gonna have it. All she need is somebody to wrap it up and put some clothes on it. Fact of business, she can get up and do that herself.”⁵⁷ White Sheppard-Towner nurses rejected this laissez-faire attitude towards childbirth and, applying the racist assumptions of the era, they confirmed that African American mothers were essentially animal-like in nature. White nurses then interpreted black mothers’ reluctance to engage a doctor as an indifferent negligence towards their unborn child.⁵⁸

Beyond the perception of childbirth being a natural event, a fundamental distrust of white doctors also made black women reluctant to seek medical help even for the required pre-natal examination. Again the midwife’s culturally elevated position was crucial in overcoming this barrier. In her work on medical experimentation on African Americans, Harriet Washington coined the term *iatrosphobia*, a fear of medicine, which she argues, continues to detrimentally impact the health of black Americans today. Onnie Lee Logan acknowledged this fear recalling that in the past, black people were treated as less than human. She understood their hesitancy because “they thought the doctors would do some kinda experiment on em. Removin’ this an removin’ that because it was nothing but a black body.”⁵⁹ Dr. Helen Barnes, an African American obstetrician beginning her practice in Mississippi in the early 1960s also observed this widespread suspicion.⁶⁰ By showing cultural empathy the midwives were able to persuade women to undergo a medical examination during pregnancy, and provide the necessary reassurance. As already demonstrated, the midwives worked in the clinics and

⁵⁷ Logan, 130.

⁵⁸ Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge, MA: Harvard University Press), Ch 6.

⁵⁹ Logan, 102.

⁶⁰ Dr. Helen Barnes, interview by Jenny Luke, Jackson, Mississippi, December 29th, 2012

accompanied women to appointments to ensure that the women they served received an improved standard of maternity care in accessing macro-level care.

The spiritual component of care was fundamental to both the midwife and the woman. A lay midwife's claim to authority was rooted in a deep spirituality and a belief in her God-given skills, and conversely, a woman's confidence in the midwife lay in her acceptance that the midwife's actions were guided by a higher power. The religious component of care is inextricably linked to the psychological when considered in a cultural context. In the absence of any medical care, trust was placed into the hands of the midwives and their specific remedies and treatments. One lady said of her midwife: "Couldn't no doctor in town or anywhere else could of made me feel any better than Mrs. Smith in assuring me that everything was going to be all right, and it was."⁶¹

Traditional practices such as herbal teas to augment labor, placing a knife under the bed to relieve pain, and perineal and abdominal massage endured despite the county health departments legislating against their use. Laboring women demanded that their midwives employ such methods as they brought a sense of comfort and familiarity to an anxiety-provoking experience. The placebo effect may have been responsible for the perceived efficacy of some practices. Mrs. Smith admitted that she had to stop using teas because her name became associated with "illegal" practice and she was afraid she would lose her license. Women used to ask her, "Miss Margaret, how come you are not using some of that stuff you used on Emma or Lucille? She was telling me about what good stuff you had. Why don't you give me some? Fix me some so I can get through with this baby."⁶²

⁶¹ Margaret Charles Smith, 83.

⁶² Ibid, 99.

An accurate assessment of how frequently traditional practices were used is impossible. However, it is clear that lay midwives were often placed in a dilemma as to whether to risk possible disciplinary action or practice beyond the realm of legal stipulation. There are many documented episodes of skilled lay midwives acting beyond their formal scope of practice in the event of an emergency. Mrs. Rosie Smith from Lowndes County, Alabama recalled delivering a woman who was bleeding as a result of a retained placenta. Mrs. Smith said, "I knew it was against the law....we didn't have nobody to go get the doctor....so finally I just decided. I know this is against the law, but it is against the law for you to lay there in this condition for too long". Mrs. Smith performed a manual removal of the placenta allowing the woman's uterus to contract preventing further hemorrhage. She did not lose her license, and when later praised for saving a life, she merely thanked the Lord for his guidance.⁶³ Restrictions on practice gradually reinforced to both lay midwives and women that midwifery was an inadequate service that should be usurped by scientific obstetrics and that ultimate knowledge lay in the hand of doctors and the realm of macro care.

Beyond their specific skills in midwifery, lay midwives also provided practical household help to the laboring women and her family. They would remain with the woman throughout labor and in addition, often cooked and cleaned as well as help with other children. Onnie Lee Logan recalled that some mothers had nothing for their baby to wear and "in between contractions [she'd] take an old skirt and make somethin' for that baby to put on when it got here". Other midwives did the same.⁶⁴ This personalized care could not be replicated in the professionalized physician-led model of care. In fact, the

⁶³ Linda Janet Holmes, "African American Midwives in the South" in *The American Way of Birth*, ed. Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 277.

⁶⁴ Logan, 95; Claudine Curry Smith, 56; Susan L. Smith, 120; Milton, 47.

attention to the personal, individual needs of a woman was interpreted as a sign of primitive care. Rigid order and procedure were valued more highly than flexibility and adaptability to specific needs.⁶⁵

The midwives' license only required them to complete and submit a birth certificate within seven days of delivery, so much of their postpartum work was done on their own initiative. They would return regularly to monitor the mother and infant. Claudine Curry Smith visited "for three days straight, to check the cord. The baby was the main reason I was coming back, but I would check the mother too. I'd ask her if everything was all right and if she didn't give me a good answer, I'd recommend her to go to the doctor. Then I'd go every other day until the cord dropped off and was all healed. Then my work was complete."⁶⁶ Culturally specific postpartum customs were largely supported by lay midwives, but most were geographically specific. The rituals were thought to bring good fortune to the infant, and strengthen the mother in her depleted post-partum state. Margaret Charles Smith recalled the "rituals of reintegration" familiar to her. They included the taking-up ceremony when the baby was carried around the house a number of times, and a three-day ceremony that required the smoking of the new mother's clothes. She admitted her skepticism of some, but nonetheless respected the tradition of women recuperating at home for four to six weeks following delivery.⁶⁷ This custom gradually eroded with the shift to hospital birth.

Clearly African American lay midwives' prestigious position in the community and trusted relationship with women enabled them to fulfill many of the micro components of care that healthcare policy experts today believe should be integral but most often lacking in care models. However, lay midwives' access to the macro level was limited resulting in

⁶⁵ Sandelowski, 68-70.

⁶⁶ Claudine Curry Smith, 65.

⁶⁷ Margaret Charles Smith, 43.

unbalanced and inadequate care. Although evidence reveals many instances of mutual respect between individual black lay midwives and white doctors, the midwives on whom documentation exists all decry the lack of support by the larger medical establishment. Generally speaking the lay midwives were confident enough in their ability and authority to demand emergency support when necessary.

Their confidence, however, met twin problems--the scarcity of doctors across the rural South and the inaccessibility to hospital—which produced mixed results at best. Both circumstances were accepted as a matter of fact by the black community there. Mrs. Margaret Charles Smith remembered four or five instances when she had to transport women a distance of 170 miles to Tuskegee to receive emergency care. She knew that it was in the best interest of the women to make the long journey there rather than to seek help at a closer hospital from which she was certain she would be turned away.⁶⁸ Claudine Curry Smith had a 70-mile drive to Richmond in the event of an obstetric emergency.⁶⁹ In describing incidents such as these, both midwives recall being stopped by the police for exceeding the speed limit. In some cases, they were able to negotiate a high-speed escort to hospital such was their reputation and authority.⁷⁰

Evidence suggests that the lay midwives felt a more effective solution to a complication at delivery was to take a woman to the local doctor, rather than expecting the doctor to go to the woman. Onnie Lee Logan did not recall “a single doctor deliverin’ a black baby at home”, and she humorously added, “cause if they sent for him the baby woulda been there and probably some of ‘em walkin’ befo’ he got there.”⁷¹ By taking her

⁶⁸ Ibid, 104.

⁶⁹ Claudine Curry Smith, 96.

⁷⁰ Milton, 77.

⁷¹ Logan, 59.

to the doctor, the midwife retained control of the situation, thereby forcing access to the macro level care.

The midwives' recollection of working with doctors shows a reluctance on the part of some doctors to serve poor black women. When Gladys Milton asked if a doctor would deliver black babies he replied, "Not if I can help it", but later did offer his services.⁷² Lay midwives were required by law to have medical approval that a woman was fit for midwife delivery at home. This permit also committed the doctor to support the midwife in the event of complications. Claudine Curry Smith's recollection of this procedure illustrates the tenacity sometimes required by the midwife in order to gain support from a recalcitrant doctor:

Some would come at the last minute but they had to have the card or else I couldn't deliver them. Now some of 'em would call me and hadn't been to a doctor, and I couldn't go unless I called the doctor.I called him and he said, 'Well you can go up there and deliver her if you want to.' Says, 'she'll be all right.' I said, 'Dr. _____, if I get up there and I need you, are you coming?' He said, 'Oh she's all right,' this, that and the other. I said, 'Well unless you tell me you're coming I'm not going.' So finally he said, 'well, go ahead, but I don't think you have no problem.' I said, 'But you said if I have a problem you'll come. Is that what you're saying?' and he told me, 'Yeah'.⁷³

Clearly lay midwives saw themselves as important advocates in enabling women to access macro level care. When a doctor did respond to a call for help at a woman's home, the midwife ensured he met his professional and legal obligations as best she

⁷² Milton, 36.

⁷³ Claudine Curry Smith, 60.

could. Maude Bryant in North Carolina remembered calling in a doctor to help her during an unusually difficult labor. After a cursory examination the doctor declared nothing to be wrong and prepared to leave. The midwife followed him outside and told him very firmly that the labor was not going well, and “something must be done, and I want you to go back in there.” She was successful in persuading the doctor to reexamine the woman, after which he took her to a hospital.⁷⁴

However, there is much documented evidence of lay midwives and doctors developing a supportive working relationship. Dr. Ruker Staggers held Margaret Charles Smith’s ability in high regard, and he knew that when she requested his help there was a serious complication of labor and he did not hesitate to act.⁷⁵ Dr. Melvin Lamberth was complimentary about Claudine Curry Smith’s skills admitting that although he “taught her a few things about medicine and obstetrics, she [Claudine] taught me [him] a few things too, like how to treat people at home.” He said they had a “fine relationship.”⁷⁶

The cumulative affect of the advocacy of lay midwives was greater access to the facilities of macro level health care, and an improved more scientific standard of midwifery care. However, the inadequate distribution of doctors and hospitals across the rural South was an insurmountable obstacle to truly improving maternity care. This, and other factors contributing to the inaccessibility of the larger medical establishment lay outside the realm and influence of lay midwives. Systemic racism within the macro structures of health care meant that state funds for improving maternity care were allocated reluctantly or insufficiently. The dire economic conditions for most African Americans in the rural South meant that until the introduction of Medicaid after 1965 few could afford the medical fees demanded by doctors. The knowledge and skill of lay

⁷⁴ Susan L. Smith, 140.

⁷⁵ Margaret Charles Smith, 88.

⁷⁶ Claudine Curry Smith, 120.

midwives was not valued by the hegemonic medical establishment; rather, they were viewed through a biased lens that deemed empirical knowledge to be inferior to scientific expertise. This opinion was buttressed by pervasive and derogatory racial assumptions of African American intellect and capability to function independently.

Thus, many macro elements of maternity care remained largely beyond the reach of lay midwives and the women they served. However, lay midwives excelled at the provision of micro level care, recognized now by modern health policy writers as being integral components of good care. Approaching the role of lay midwifery from a micro/macro perspective does expose the inadequacy of the care they were able to give. Nevertheless, when applied to long-term changes in maternity care across the twentieth century, those aspects of care so closely associated with lay midwifery become highlighted as crucial elements of maternity care so often missing in modern poorly served communities.

Chapter 3

Asafetida to Aureomycin: African American Nurse-Midwives, 1930-1950

The December 10, 1951, issue of the magazine *Life*, included a remarkable photo-essay that prompted an overwhelming response from its readership. It was the work of renowned photojournalist W. Eugene Smith entitled “Nurse Midwife: Maude Callen Eases the Pain of Birth, Life, and Death”. The subject of the article, Maude Callen, was an African American nurse-midwife who provided vital life-saving services to the impoverished, rural population of Berkeley County, South Carolina.⁷⁷ During the weeks following its publication hundreds of letters and monetary donations poured in from readers, such was the overwhelming support of Callen’s selfless devotion to her community. So many donations were sent, in fact, that Callen was able to establish a clinic for her patients. A registered nurse as well as a midwife, she was described in the article as being as far removed from a “granny” or lay midwife as “ aureomycin is from asafetida.”⁷⁸ In other words, she embraced the scientific advances of modern medicine (antibiotics) and had turned her back on traditional, herbal remedies (asafetida). A nurse-midwife, the article suggests, was the antithesis of a “granny”; she was a college-educated, professional woman who embraced a modern and scientific approach to health care.

⁷⁷ W. Eugene Smith, “Nurse Midwife: Maude Callen Eases the Pain of Birth, Life and Death,” *Life* December 3, 1951, 134-145. W. Eugene Smith (1918-1978) was a controversial “humanistic” photo-journalist who used his work to raise social consciousness and affect change. His other important works depict battlefield conditions in the Pacific theater of WW II, the lives of miners in post-WW II South Wales, and the effects of mercury poisoning in a Japanese community.

⁷⁸ *Ibid*, 135.

And yet Maude Callen and her colleagues also recognized the value in much of the care administered by lay midwives. Nurse-midwives, black and white, working in the southern states provided a bridge to communities that were almost completely devoid of medical professionals, and the state and federal health care system. They set forth a framework under which licensed lay midwives could safely and effectively practice and they, like the women they supervised, were entirely committed to the communities they served. The analogy used by Smith in his photo-essay is indicative of the acknowledged acceptance of the march of scientific progress during the mid-twentieth century. But those assumptions are belied by the experience of nurse-midwives. Although a scientific approach awarded little value to what was considered archaic, some remedies were effective and reassuringly familiar to the community.

During the 1940s, nurse-midwives in the southern states found balance between science and cultural tradition, and were able to significantly improve the childbearing experience and outcome for women in the communities they served; they offered an alternative to patriarchal medical care. Working as part of a team the nurse-midwife was able to address both the micro- and macro- components of good maternal care. She was able to compromise when necessary to adapt to the personal, cultural, and social needs of a women, and yet she was a skilled, autonomous practitioner with access, when geographically available, to the larger medical community; she had, if you will, a foot in both camps. At a place and time when lay midwives were the sole providers of maternal care for many women, nurse-midwives did not tolerate harmful superstition, but rather coaxed, supervised, and trained capable lay midwives, ushering in a more modern maternity care.

But that balancing act came at a price. Given that the nurse-midwife's role brought her into contact with local and state governmental bodies, the macro components

of care, she faced prevalent negative forces of racial, gender, and professional discrimination. The constraints of working in the Jim Crow South were of course particularly detrimental for African American nurse-midwives.

As professionals, nurse-midwives fought for a place within a multi-disciplinary arena in which to practice. The origin of the struggle lies in the medical profession's claim that embracing midwifery as a branch of nursing would lessen the prestige of obstetrics as a medical specialty, as well as create a competitive economic market for doctors. Coinciding with the period of professionalization of physicians and specialization within that group, the debate on midwifery in the early decades of the twentieth century was fervent. Obstetrician, Joseph B. De Lee, declared in 1915 that even a trained midwife "is a drag on the progress of the science and the art of obstetrics. Her existence stunts the one and degrades the other. For many centuries she prevented obstetrics from obtaining any standing at all among the sciences of medicine."⁷⁹ Dr. De Lee succeeded in leading the charge towards the medicalization of childbirth and (as he would see it) in keeping with the promise of the scientific age "childbirth [was] lifted out of the realm of darkness into the spotlight of new science."⁸⁰ Though this chapter argues against most of De Lee's premises, there is no denying that De Lee was an advocate for improving maternity care. He took "second place to no man or woman in [his] regard for the poor, the ignorant, the foreign-born, childbearing mother."⁸¹ To this end he established the Chicago Maternity Center to serve the poor, immigrant community on the south side of the city. Here, he

⁷⁹ Joseph B. De Lee, "Progress Toward Ideal Obsterics," *Transactions of the American Association for the Study and Prevention of Infant Mortality*, 6 (1915), 114-123, in *The American Midwife Debate: A Sourcebook on its Modern Origins*, Ed. Judy Litoff (New York: Greenwood Press, 1986), 102.

⁸⁰ *Good Housekeeping*, (1926), 88:270, quoted in Judith Walzer Leavitt, "Joseph B. De Lee and the Practice of Preventive Obstetrics," *American Journal of Public Health*, Vol. 78, No. 10 (1988): 1353 – 1361.

⁸¹ De Lee, 105.

and his team of physicians, medical students, and nurses provided pre-natal care and free home delivery to those women previously registered with the center.

There is irony then that Dr. De Lee's goals, and in many respects his actions, actually expanded the role of nurse-midwives. In 1918, a small group of mothers, obstetricians and nurses established the Maternity Center Association (MCA) in New York City, following in the footsteps of De Lee's Chicago Maternity Center. The Association set itself three tasks: to open neighborhood maternity centers in cooperation with other health agencies in the city; to find pregnant women and encourage them to use their local center for pre- and post-natal care as well as for delivery; and to study and standardize maternity care throughout the city, supported by obstetrical care.⁸² It quickly became apparent that few nurses were adequately equipped to provide the very specialized type of care required by a woman in childbirth.

Along with the Progressive-era push to improve immigrant maternal care, another influence on the expansion of nurse-midwives in the U.S. was the contrasting path of development of obstetric care in Europe. Unlike the situation in the United States, obstetricians in Europe felt neither competition, nor animosity towards well-trained midwives practicing within a medically supervised model of care. In fact, the British Parliament sanctioned the practice of midwifery in 1902 by establishing the Central Midwives Board that regulated training, conducted examinations, and certified successful candidates. The physicians on the medical board of the MCA supported a shift towards medically supervised midwifery in order to enhance maternal care in America. Board member Dr. Benjamin P. Watson, professor of obstetrics and gynecology at the College of Physicians and Surgeons at Columbia University, believed that "the maternal mortality

⁸² Maternity Center Association, *Twenty Years of Nurse-Midwifery 1933-1953* (New York: Maternity center Association, 1955), 12.

in this and every other country would be materially reduced if the practice of obstetrics were in the hands of thoroughly trained midwives working in conjunction with and under the direction of properly trained doctors.”⁸³ The editor of the *American Journal of Obstetrics and Gynecology*, Dr. George W. Kosmak also argued for a European-style midwifery service declaring that, “there is no branch of medicine in which the nurse participates to such an important degree as in obstetrics.”⁸⁴

Although most U.S. physicians voiced their outright opposition to midwifery, or a grudging acceptance of midwives being a temporary “necessary evil”, some held firm as proponents of a well-trained body of midwives and of the superior service it could provide. Most supporters of raising the status of midwifery and, or, grafting it onto nursing were doctors who viewed the situation from a wider perspective. These allies came from the realm of public health or pediatrics and understood the role of the midwife to be greater than simply delivering a child; they recognized the value of micro factors as being essential for good maternity care. The role of the midwife, they argued was quite different to that of the obstetrician and, to alleviate fears of economic competition, claimed that it should not “invade the province of the physician.” Writing in a 1914 public health journal, Carolyn Conant Van Blarcom, a nurse educator with extensive knowledge of European midwifery regulatory programs, argued that greater value should be given to the services provided by trained midwives such as intelligent nursing care for the mother and infant during the twelve to fourteen days after delivery, advising the mother on questions of hygiene before and after delivery, as well as teaching the mother proper infant care -- all

⁸³ Ibid, 13.

⁸⁴ Ibid, 14.

services that fell outside the scope of medical practice.⁸⁵ Eminent pediatrician, Dr. Abraham Jacobi, during his tenure as president of the American Medical Association in 1912 also supported a European-style midwifery service, and saw the extended role of trained midwives as an essential component of a modern, effective response to high infant mortality rates. He remarked that, “a town without an ample supply of good doctors and midwives and a village without one or two competent and responsible and licensed midwives, are like a tenement house without a fire-escape or a Titanic without life-boats!”⁸⁶

Perhaps because these ideas were new and still controversial, however, the MCA struggled to establish a school of nurse-midwifery to help serve New York’s mothers throughout the 1920s. Some of the most vociferous opposition came from nursing leaders themselves. They argued that public health nurses did not want to assume the added responsibility of midwifery. They, like most physicians, understood the role of the midwife to simply be their presence at birth and underestimated the importance of thorough pre-natal, post-natal, and infant care in a more holistic approach. Two nurse leaders, one with extensive urban public health experience and one with rural experience, thought that most competent nurses would feel adequately prepared to face an emergency delivery and in addition, they were generally too busy to assume any further duties. Other nurse leaders were afraid of tainting the reputation of public health nurses by their association with midwifery. By the racialized standards of the time,

⁸⁵ Carolyn Conant Van Blarcom, “Midwives in America,” *American Journal of Public Health*, 4 (March, 1914), 197-207 in Litoff, 174.

⁸⁶ Abraham Jacobi, “The Best Means of Combatting Infant Mortality,” *Journal of the American Medical Association*, 58 (June, 1912), 17-35-1744, in Litoff, 177-199.

traditional midwives of African or European descent were considered to be ignorant, dangerous, and certainly unprofessional.⁸⁷

However, by 1932 the MCA, licensed by the New York City Board of Health with supervision by the Health department's Bureau of Maternal and Child Hygiene, opened as a school of nurse-midwifery, graduating its first class in 1933.⁸⁸ The governing body of MCA was pragmatic in its approach to the training of American nurse-midwives. Although they looked to Britain as a model, American needs were unique and the goals, curriculum, and candidate requirements were modified as necessary. The initial objective of the school was to "prepare nurse-midwives to assume responsibility for the supervision, care, and instruction of women during pregnancy, labor, and the puerperium, under the guidance of a competent obstetrician."⁸⁹ However, given the heavy distribution of traditional lay midwives in rural areas, particularly in the South where few physicians practiced, the school leadership recognized that in order to be successful they needed to train nurse-midwives to primarily supervise lay midwives, and to secondarily provide professional maternity care.⁹⁰ This shift in objective can be seen in the selection of students for admission. Although officially requiring that applicants be eligible for admission to university, admissions officers often overlooked this stipulation in favor of seasoned professionals, or public health nurses who were to return to areas of the country, and in fact the world, with particularly poor maternal care.⁹¹ The dispersion of those nurse-midwives graduating between 1933 and 1953 as listed in the report

⁸⁷ Laura Ettinger, *Nurse-Midwifery: The Birth of a New Profession* (Columbus: The Ohio State University Press, 2006), 81.

⁸⁸ Maternity Center Association, 18,19.

⁸⁹ Ibid, 18. The puerperium is the period of time following delivery during which the uterus returns to its normal state. Usually considered to be six weeks.

⁹⁰ Ettinger, 85.

⁹¹ Maternity Center Association, 25-26; Ettinger, 88.

published by MCA in 1953 reveals their focus on students willing to return to places of need.⁹² The success of the program lay in the blended emphasis on nurse-midwives being educators, organizers, and administrators as well as ensuring that a woman not only received safe maternity care, but also a type of care that paid attention to the social and emotional aspects of childbearing.⁹³

The twenty-year report of the MCA published in 1955 applauds the successes of the program. It indicated that mortality and morbidity statistics were markedly reduced but also evaluated the micro-factors of good maternal care. The report noted that the easily accessible clinic was regularly attended during pregnancy, with each woman making an average of 7.7 pre-natal visits.⁹⁴ Moreover, stories attest to how the staff made each patient feel comfortable and the women realized that the nurse-midwives were genuinely interested in her welfare. They fostered a relationship of trust so that women were more receptive to counseling about diet, hygiene, and expectations for delivery. The women could visit the clinic at their convenience when they had ample time to ask questions, and the friendly atmosphere contrasted sharply to that found in many typical pre-natal clinics where:

Long lines of patients waiting to be seen by the physician, inadequate antepartum care according to acceptable standards, little or no counseling, little attention paid to maternal nutrition, and little or no privacy afforded the patient or other satisfying experience, that would induce the pregnant woman to register early for her

⁹² Maternity Center Association, 117-124.

⁹³ Ibid, 115.

⁹⁴ Ibid, 28.

antepartum care and to continue it without interruption during her pregnancy.⁹⁵

The importance of this relationship building, MCA argued, was reflected in the fact that despite prevalent economic deprivation within the patient group, five out of six women found time to return to the clinic for a post-natal visit six weeks after delivery.⁹⁶

The nurse-midwives graduated with a clear sense of the importance of the micro-factors of good maternal care: support networks, outreach, dissemination of knowledge in terms relevant to women, and cultural perspectives. They carried this philosophy with them out into the field. Nowhere was in greater need of improvement to maternal and infant care than the poor, rural communities of the South, and yet the inclusion of a nurse-midwifery service into the state boards of health was entirely dependent on the senior medical officials' general perception of the midwife.

The reception New York educated nurse-midwives encountered in the South varied. In 1941, associate director of Georgia's Division of Maternal and Child Health, Edwin R. Watson, held the view that African American midwives' "false beliefs are fixed ideas and cannot be changed" and so was unwilling to invest in improving their skills.⁹⁷ However, in other southern states, medical officials claimed the atrocious maternal mortality and morbidity was as much a result of impoverished mothers having no prenatal care, often suffering from chronic disease and malnutrition, than as a consequence of

⁹⁵ H.M. Wallace M.D., "Trends in Maternal and Perinatal Mortality in New York City," *Journal of American Medical Association*, (June, 1954), 717 qtd in Maternity Center Association, 29.

⁹⁶ Maternity Center Association, 36.

⁹⁷ Patricia Evridge Hill, "Dr. Hilla Sheriff: Caught Between Science and the State at the South Carolina Midwife Training Institutes," in *South Carolina Women: Their Lives and Times, Volume 3*, ed. Marjorie Julian Spruill, Valinda W. Littlefield, and Joan Marie Johnson (Athens: University of Georgia Press, 2012), 84.

care delivered by traditional midwives.⁹⁸ Dr. Hilla Sheriff of South Carolina, Dr. Frances Catherine Rothert of Arkansas, Dr. J.N. Baker of Alabama, each saw the potential benefits in the adoption of a nurse-midwifery service. In Maryland, Dr. Charles H. Peckham had his foresight confirmed when in 1939, just three years after introducing a supervising nurse-midwifery service he declared that “in communities where a nurse-midwife has been employed the general level of obstetric care has always improved with remarkable celerity.”⁹⁹

The impressive attendance rates that the MCA earned at their pre-natal clinics were in themselves responsible in part for reducing the mortality rates. Dr. Frances Rothert, under the auspices of the Children’s Bureau, had analyzed the maternal mortality figures from fifteen states. Her report found that the absence of pre-natal care was a common factor in case of maternal death. Of rural black women, 83 percent had no prenatal care and 13 percent had what was classified as inadequate care.¹⁰⁰ This report published in 1934, based on mortality figures of 1927-1928, strongly reinforced the urgent need for the provision of on-going maternity care starting with the onset of pregnancy. The fact that poor rural women were dying at higher rates than urban women indicated that state departments of health needed to establish a service that could reach isolated, largely ignored communities.

Some graduates of MCA held supervisory positions in departments of health across the South. Working as an advisor to the Alabama State Department of Health, Margaret Murphy, a 1933 graduate, was instrumental in the establishment of a school of

⁹⁸ Hill, 85.

⁹⁹ Charles H. Peckham, “The Essentials of Adequate Maternal Care in Rural Areas,” *The Child*, vol 5, (November, 1939), 123, in Maternity Center Association, 56.

¹⁰⁰ Francis Rothert, *Maternal Mortality in Fifteen States* (Washington D.C.: Department of Labor, Children’s Bureau Publication Number 223, 1934), 63.

nurse-midwifery in Tuskegee. Under the auspices of the Julius Rosenwald Fund, the federal Children's Bureau, and the MCA, Tuskegee's program in nurse-midwifery was the first serious attempt to supply adequate maternity care to poor families in the rural South. The school's principle objectives were to educate graduate African American nurses in midwifery, to reduce maternal and infant mortality, to study the specific problems of providing care in rural areas where medical services were not available, and to improve the service provided by John A. Andrew Memorial Hospital. Moreover, the school was seen as a "pioneer venture in negro education."¹⁰¹

The Tuskegee School of Nurse-Midwifery opened in September 1941 under the direction and leadership of MCA trained nurse-midwives, with medical supervision by the hospital and the Tuskegee Institute. Although fraught with problems of personnel retention, recruitment, and lack of real commitment from the Institute and hospital, the school graduated thirty-one African American nurse-midwives before closing in 1946. Despite its short life, the nurse-midwifery service provided by the school made a significant difference in the maternal mortality rate in Macon County. When the school opened, 8.5 women died per 1000 live births but by the second year, the service delivered one-third of all mothers in the county with a mortality rate of zero.¹⁰² By addressing issues specific to the community, the nurse-midwives working within a larger framework of state health care provision were able to foster better relationships with the women and families they served. That women were happy with the care they received, and thus the effectiveness of counseling, is evidenced in the reduction in mortality that came as a direct result of early and consistent pre-natal care.

¹⁰¹ Maternity Center Association, 58, 59.

¹⁰² *Ibid*, 61.

Who were these African American nurse-midwives and how did they differ from lay midwives? The micro-macro approach employed in this study highlights the differences between the two groups of health care providers. The lower social status of the lay midwives, although maligned by most in the wider medical community, afforded them some protection from racial and gender discrimination because their sphere of influence was at the grassroots, community level where they held a relatively high degree of authority; they functioned mainly at the micro level and so could avoid (by “flying under the radar,” so to speak) the contempt and influence-erosion of the medical and state officials. In contrast, the African American nurse-midwives were middle-class and, by virtue of their position within the larger society, came face to face with the almost insurmountable obstacles of discrimination imposed on them as they functioned within the broader framework of local, state, and federal health care. These macro-structural components influenced their experiences as professionals, as women, the care they were able to provide, and the longevity of the nurse-midwife service.

Uncovering the precise fate of the Tuskegee-trained nurse midwives is difficult, because the Tuskegee Institute did not formally embrace the program as part of the university and so neglected to preserve its history in the archives. However, using a 1994 nursing master’s thesis, we can piece together information for about one-third (ten of thirty-one) of their graduates.¹⁰³ They were dedicated and talented women.

Comparing Tuskegee’s requirements for admission to MCA’s reveals a disparity between the educational opportunities for black and white nurses. The program in New York observed a rise in the preliminary educational level of its applicants, with 67 per cent

¹⁰³ Lucinda Canty, “ The Graduates of the Tuskegee School of Nurse-Midwifery,” Master’s thesis, Yale University, 1994.

of all graduates having at least a bachelor's degree.¹⁰⁴ Black nurses had very limited access to collegiate nursing education. As late as the mid-1930s only one black college, Florida A&M, offered a bachelor's nursing program and it was not until the mid- to-late 1940s that the other schools followed suit.¹⁰⁵ The educational requirement for admission to Tuskegee was to be a graduate of an accredited school of nursing and preferably college eligible.¹⁰⁶ Of the more than 100 training schools for black nurses only twenty-six were accredited by the National League of Nursing Education. Entry into these top tier schools required high-school graduation, some of them stipulating a high class ranking.¹⁰⁷

By cross-referencing the nursing education of the ten Tuskegee trained nurse-midwives with lists of accredited schools it becomes apparent that the African American nurses selected for the program were superior candidates: well-educated, intelligent, and some already well-accomplished.¹⁰⁸ For example, Helen Sullivan Miller, a graduate of University Hospital in Georgia, came to the Tuskegee School of Nurse-Midwifery after spending three years as a staff-nurse in the Georgia department of public health. She returned there as an area supervisor in maternal health in charge of midwife control. After a wartime stint in the Army Nurse Corps, she earned her bachelor of science in nursing

¹⁰⁴ MCA, table I, 24.

¹⁰⁵ Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*, (Bloomington: Indiana University Press, 1989), 65.

¹⁰⁶ Tuskegee Institute, *Bulletin of the Tuskegee School of Nurse-Midwifery*, Alabama, 1945, 5.

¹⁰⁷ Estelle G. Massey Riddle, "The Training and Placement of Negro Nurses." *The Journal of Negro Education*, Vol 4, (1935), 42-48, in *Black Women in the Nursing Profession: A Documentary History*, Ed. Darlene Clark Hine, (New York: Garland Publishing, Inc., 1985), 91.

¹⁰⁸ Canty, 26-36; Hine, *Black Women in the Nursing Profession*, 89-95; Hine, *Black Women in White*, 63-84.

with an emphasis on public health, before becoming the supervising nurse at the City of Philadelphia department of health. By 1957, Miller had her master's in nursing from Yale University and later became the chairman of the department of nursing at North Carolina Central University. She was the author of three books about nursing, particularly documenting the experience of black nurses, and was the recipient of several prestigious nursing awards.¹⁰⁹ This career path is not unusual when compared to other Tuskegee nurse-midwives on whom documentation is available. Moreover, the focus on public health experience for admission clearly indicates the high caliber of Tuskegee's nurse-midwife candidates, despite the dearth of collegiate nursing programs available to them. The optimal candidates were those that had at least one year of public health experience as well as one semester, or preferably two, at one of the just 17 approved programs of post-graduate study in public health.¹¹⁰

While Tuskegee's program acknowledged the importance of public health education, such was not true across the South, especially as it concerned African Americans. A census of public health nurses collected in 1926 revealed that of the 365 African American public health nurses in the U.S., only 59 were employed in the South.¹¹¹ But the appalling state of general health of the African American population in the South did lead nursing leadership, black and white, to demand better state and federal funding for a greater number of better qualified public health nurses. The time-honored theory

¹⁰⁹ Canty, 26-27.

¹¹⁰ Tuskegee Institute, *The Bulletin of the Tuskegee School of Nurse-Midwifery*, Alabama, 1945, 5. Dorothy Deming, "The Negro Nurse in Public Health" *Journal of Negro Life*, Vol 15, (November, 1937), 333-335, in Ed. Hine, *Black Women in the Nursing Profession*, 99.

¹¹¹ Abie Roberts, "Nursing Education and Opportunities for the Colored Nurse," *Proceedings of the National Conference of social Work*, (Chicago: Chicago University Press, 1928), 183-185 in Hine, *Black Women in the Nursing Profession*, 62.

that people of African descent had a pre-disposition for certain diseases such as syphilis or tuberculosis was giving way to the belief that ignorance and poor living and working conditions were more to blame for these diseases than any biological weakness. Thus, it was in this field of nursing, one that emphasized education and self-help at the community, micro-level, that the most effective work could be done if nurses were specifically trained and well-prepared. Not surprisingly, the link between gaining advances for black families was tied to the impact on white families if officials failed to act. As Darlene Clark Hine observes in her study of black nursing, a recurrent theme in black women's activism was the urgency of protecting the health of white families in whose homes black women worked. In this case, that urgency opened up a window of opportunity for black health care professionals to seize the initiative and make accessible health care available to their own communities.¹¹²

Once again, however, prejudice in the form of unequal education held back the pace of advancement. Despite the dire need for black public health nurses in the South, few black nurses held the necessary qualifications for specific study in the field because so few hospitals in the region met the requirements dictated by the National Organization of Public Health Nursing. This national body ensured that the general training curriculum included some emphasis on public health and also considered essential for success was the need to attract young African American nurses "with the best personal qualifications and background".¹¹³ It was members of this already elite group of public health nurses that were selected to become certified nurse-midwives.

¹¹² Darlene Clark Hine, "African American Women and their Communities in the Twentieth Century," *Black Women, Gender, and Families*, Vol. 1, no.1, (Spring 2007), 15.

¹¹³ Dorothy Deming, "The Negro Nurse in Public Health," *Journal of Negro Life*, Vol 15, (November, 1937), 333-335, in Ed. Hine, *Black Women in the*

This group of nursing professionals was anchored in the “modern” health care system. As previously identified, the nurse-midwives were all the products of the best hospitals and schools of nursing, and the career paths of the ten graduates reveals the extent to which they were embedded in the increasingly centralized macro health care system. Dr. John A. Kenney, in his address to the first graduating class of the Tuskegee School of Nurse-Midwifery, labeled the event auspicious “as it symbolized the transition from the old order in midwifery to the new.”¹¹⁴ He praised the unique coalition of the federal government, a philanthropic organization, a southern state, a southern county, and a “Negro” institution all working harmoniously for the development of midwives to serve the most needy of the “Negro” people.¹¹⁵

While Tuskegee’s program illustrated how nurse-midwives fit in with macro concerns about public health (and the benefits that emphasis gained for the advancement of black health in Alabama), it also points to the micro elements of nurse-midwifery. One need look no further than the curriculum designed for the program to recognize the importance placed on the specific, culturally unique, micro health needs of the community. Of the 1100 hours of instruction required to graduate, only 200 hours were spent in the classroom, and just 50 of those were assigned for the anatomy and physiology of obstetrics. The majority of class time was devoted mainly to the application of nurse-midwifery in the community, in pre- and post-natal care, parent education, lay midwife instruction and supervision, with some emphasis on trends in current practices in

Nursing Profession, 99. Nina D. Gage and Alma C. Haupt, “Some observations on Negro Nursing in the South,” *Public Health Nursing*, Vol 24, (1932), 674-680 in Ed. Hines, *Black Women in Nursing Profession*, 81-87.

¹¹⁴ John A. Kenny, “The First Graduating Class of the Tuskegee School of Midwifery,” *Journal of the National Medical Association*, Vol. 34, No. 3, (May, 1942), 107.

¹¹⁵ *Ibid*, 108.

maternal and infant care. Nurse-midwife candidates spent the bulk of the 900 hours, not in deliveries, but on home visits.¹¹⁶ Interestingly, in order to facilitate the provision of care to the homes of a widely dispersed community one of the prerequisites was that students knew how to drive. Furthermore, any student owning a car was requested to bring it with her!¹¹⁷

As the curriculum suggests though, despite their pioneering, modern approach to maternal health care, the nurse-midwives maintained some elements in common with lay midwives. Like the lay midwives who were culturally embedded in their communities, the nurse-midwives understood the importance of cultural awareness. The National Organization of Public Health Nursing promoted the replacement of white nurses by black nurses after a study revealed better results were achieved if “Negroes were met with the subtle understanding and sympathetic attention of nurses of their own race.”¹¹⁸ The public health community observed that this psychological advantage was essential to the success of any effort to improve the health of African Americans. There was unanimous opinion that black nurses could more easily gain the confidence and trust of a community. One supervisor observed, “Negro people will not tell everything to a white nurse” and a black nurse is able to “gain the confidence of her people without reservation and understands how to overcome the peculiar superstitions of the more ignorant among them.”¹¹⁹

¹¹⁶ Tuskegee Institute, *The Bulletin of the Tuskegee School of Nurse-Midwifery*, Tuskegee, Alabama, 8-10.

¹¹⁷ *Ibid*, 6.

¹¹⁸ Deming, 99.

¹¹⁹ Stanley Rayfield, “A Study of Negro Public Health Nursing,” *The Public Health Nurse*, (October, 1930), 525-536, in Ed. Hine *Black Women in the Nursing Profession*, 71.

Nevertheless, the class and educational background of the nurse-midwives could not fully prepare them for the environment in which they were to work. Dr. Kenny in his commencement speech addressed the women as “frontiers-women with trained head, heart and hands.”¹²⁰ He told them that they would be thrown upon their own resources and that many times they would, while relying on their training and judgment, be “strained to their wits end.”¹²¹ Maude Callen, for all her scientific training and expertise, was challenged by the conditions she faced in Berkley County where most of the residents were tenant farmers with an annual income of less than \$100. The farm houses were typically five miles from a paved road and almost completely inaccessible when it rained.¹²² W. Eugene Smith captures the incongruous image of Callen, wearing her neat uniform and dress shoes, carefully picking her way back to her car along a flooded, unpaved road strewn with logs and tree branches. Callen reported that this type of road was not unusual, and at the end of some of them in the 1920s, she found “people who did not know the use of forks and spoons.”¹²³ With minimal equipment costing approximately \$5, nurse-midwives were able to perform normal deliveries under aseptic conditions in the poorest, most humble homes without sanitation or electricity, for like the lay midwives they supervised, nurse-midwives were masters of improvisation.¹²⁴

A different aspect of cultural sensitivity was seen in the nurse-midwives’ respectful relationship towards the lay midwives. Lay midwives were treated with dignity and respect in their communities and recognition of their influential role was crucial to the improvement of maternal care. The lay midwives were perhaps most influential in the

¹²⁰ Kenney, 109.

¹²¹ Ibid, 109.

¹²² Hill, 86.

¹²³ Smith, 141.

¹²⁴ Ibid, 135.

education of women on a consistent daily basis, and continued to deliver pre-, post- and intra- partum care in their communities. An officer of the Division of Maternal and Child Health in South Carolina, when teaching comparisons between the modern midwife and that of her predecessor always reminded her class of nurse-midwives to “never forget the granny because if she hadn’t been willing and able to learn they wouldn’t be here.”¹²⁵

A central tenet of the philosophy of the nurse-midwife was her role as an educator within a multi-level, inter-disciplinary maternity care system. Nowhere was this more visible than in the midwifery summer institutes held each year for the training of lay midwives. Here, African American nurse-midwives formed an effective partnership with white public health officials; the state department Division of Maternal and Child Health providing funding and organizational expertise, with the nurse-midwives contributing their experience, clinical expertise, and cultural awareness. A program of midwifery education was developed most effectively in South Carolina under the direction of Dr. Hilla Sheriff. Beginning in the early 1940s lay midwives in South Carolina, in order to be licensed by the state, had to attend a two-week residential course with a refresher every fourth year. New midwives were required to attend every summer for four consecutive years.¹²⁶ Through this program nurse-midwives functioned as vectors in a system that promoted the dissemination of medical knowledge and practice resulting in the desired reduction in maternal and infant mortality.¹²⁷

Viewed in the context of the summer institutes, the gulf between the nurse-midwives and the lay midwives was enormous and yet there was some blurring of the

¹²⁵ Ibid, 89.

¹²⁶ Hill, 77.

¹²⁷ In South Carolina the maternal mortality rate fell from 540 per 10,000 live births in 1945 to 175 per 10,000 in 1957. The number of stillbirths per 1000 fell from 47.4 to 27.1 between the same years.

spheres of influence in the hierarchy of practice. Given the rarity of certified nurse-midwives, the most reliable and capable lay midwives, those who abided by state law and regularly attended the midwife meetings, were granted a leadership role at the institutes and at the community level.¹²⁸ Group leaders handpicked by the nurse-midwives—women such as Mamie Stokes and Edith Baylor—designed group activities and had the authority to “preside over community meetings, dispense silver nitrate, inspect midwives’ bags, and ensure that any new members learned the revered “Midwife Song.”¹²⁹ The selection of lay midwife leaders again demonstrates the nurse-midwives’ tendency to focus on the individual, be she a lay midwife or expectant woman, to optimize the outcome. In the choice of lay midwife leaders, the nurse-midwives narrowed their focus to assess an individual who showed potential, reliability, and a genuine desire to learn scientific methods. They created a top tier of lay midwives in whom they could trust to reinforce modern techniques and standards of care.

Though they focused on individuals, they did not ignore the benefits of schooling, and so it can be reasonably assumed that the selection of leaders was directly related to age and education level. Many of the lay midwives attending the institutional courses required for licensing were taught to read and write during training as “few had more than a fourth grade education.”¹³⁰ Maude Callen and Eugenia Broughton were particularly influential in adding basic literacy to the summer programs in South Carolina. Midwife Josephine Matthews gratefully acknowledged that one unexpected aspect of being a lay

¹²⁸ Laura Blackburn, “The Midwife Problem in Rural Areas of the South,” *The Trained Nurse and Hospital Review*, 1939, 129.

¹²⁹ Hill, 87; James H. Ferguson, “Mississippi Midwives,” *Journal of the History of Medicine*, (Winter, 1950), 89; Mamie Stokes and Edith Baylor, Group leaders selected by Laura Blackburn at the Penn School, S.C., Images of the History of Medicine Collection, Archives, 1946-76, box 10.

<http://ihm.nlm.nih.gov/luna/servlet/view/search?q=B09895>

¹³⁰ Smith, 145.

midwife was that she earned a high school diploma at the age of 74.¹³¹ In a late 1950s sociological study of lay midwifery in North Carolina, Beatrice Mongeau attempted to make a connection between literacy and success in practice. She concluded that having a literate body of lay midwives resulted in a more equal distribution of practice; an illiterate group tended towards a monopolizing concentration of power in an individual according to her personal attributes and skills.¹³² Clearly, a more equitable distribution of midwifery service better served the community, which validates Callen's and Broughton's argument to include reading and writing in their program.

To overcome the discrepancy in educational levels the curriculum was presented using a variety of culturally relevant techniques. Skits and role-playing were devised to "ridicule" old superstitions and emphasize modern methods, and puppets were used to practice dialogues useful for educating women in the communities.¹³³ Colloquial expressions and familiar terms replaced medical jargon. Lay midwives were taught to ensure the placenta was delivered intact. The placenta is lobular and has the appearance of a pan of cooked biscuits. Mrs. Smith says she was taught to make sure that "none of the biscuits were missing" because retention of part of the placenta leads to excessive bleeding and infection.¹³⁴ Instructions and procedures were set to familiar tunes so that standards of modern care could be more easily taught and remembered, particularly by those lay midwives at a lower literacy level. One such technique is illustrated by the "The Midwife Song", and featured regularly at midwife meetings. The lyrics, sung to the tune of

¹³¹ Hill, 87.

¹³² Beatrice Mongeau, "The Granny Midwife: Changing Roles and Functions of a Folk Practitioner," *American Journal of Sociology*, Vol. 66, No. 5 (Mar, 1961), 497-505.

¹³³ Blackburn, 130; Midwives using Puppets, Utilizing puppets to role-play, Images of the History of Medicine Collection, Archives, 1946-76, box 12. <http://ihm.nlm.nih.gov/luna/servlet/view/search?q=B09967>

¹³⁴ Margaret Charles Smith, 96.

“Mary Had a Little Lamb”, described proper dress and scrubbing procedure for delivery, and specific hand motions accompanied each verse.

Why does the midwife wear a wash dress? (Hold dress)

Wear a wash dress, wear a wash dress?

Why does a midwife wear a wash dress?

TO PROTECT THE MOTHER AND BABY. (Claps hands)

Why does the midwife wear a clean cap? (Points to cap)

Wear a clean cap, wear a clean cap?

Why does the midwife wear a clean cap?

TO PROTECT THE MOTHER AND BABY.¹³⁵ (Claps hands)

In keeping with the holistic approach to good maternal health, the nurse-midwives incorporated an inter-disciplinary aspect to the curriculum at the institutes. Dietitians, mental health consultants, public health nurses, and doctors collaborated with the nurse-midwives to review lesson plans and schedule activities to optimize the efficacy of the training.¹³⁶ Working within a team supported by medical personnel was a hallmark of the nurse-midwife's role and there existed a surprising degree of mutual respect between the African American nurse-midwives and their largely white colleagues from the state departments of health. The pragmatism of the public health officers that were sincerely committed to improving the standard and accessibility of maternal care in the

¹³⁵ Ferguson, 92.

¹³⁶ An Inter-disciplinary Meeting, Images of the History of Medicine Collection, Archives, 1946-76, box 10.
<http://ihm.nlm.nih.gov/luna/servlet/view/search?q=A014832>

Jim Crow South frequently took precedence over the accustomed social mores of that region.

Relying heavily on African American nurse-midwives at the division of Maternal and Child Health in South Carolina, Dr. Hilla Sheriff, who was white, promoted an atmosphere of interracial cooperation. During a lecture by a visiting physician, Sheriff removed a screen that was segregating the audience. She argued that it over-complicated the question and answer session that ended the talk, explaining that the “doctor was a busy man who had little time for such nonsense.” She highly valued the work of the nurse-midwives and despite being the first American woman to earn a master’s degree in public health from Harvard University asserted, “I think I learned more about public health from public health nurses than I learned in any other place.”¹³⁷ Of course, many public health nurses were white but Sheriff’s close professional relationship with African American nurse-midwives Eugenia Broughton and Maude Callen, and the trust she placed in their judgment in developing the summer institutes, suggests that she was not only proud to include black nurses in her multi-disciplinary team, but also felt it important to afford them the recognition they deserved. Dr. William K. Fishbourne, the head of Berkeley County health department, agreed with Sheriff’s assessment of these professional health-care providers. When asked if Callen could be spared to do some teaching for the state department of health, the physician is quoted as saying, “If you have to take her, I only ask that you join me in prayer for the people left here.”¹³⁸ With too few doctors to administer care, Fishbourne gratefully relied on Callen to relieve the burden of his enormous workload.¹³⁹ Similarly, Tuskegee nurse-midwife, Mamie O. Hale, was a well-known and respected figure among white public health nurses and

¹³⁷ Hill, 90.

¹³⁸ Smith, 135.

¹³⁹ Ibid, 142.

obstetricians in Arkansas. In deference to her, Hale's white colleagues, when traveling throughout the state with her, boycotted restaurants that refused to serve African Americans.¹⁴⁰ At this level of professional interaction, racial stereotyping could be superseded by reputation and character.

And yet, despite these apparently harmonious relationships built on a platform of respect and collaboration, African American nurse-midwives faced enormous obstacles. The wider structural forces of legally sanctioned racial discrimination severely limited the long-term success of the service. Despite meeting its objectives, the funds for the Tuskegee School of Nurse-Midwifery were redirected in 1946, thus ending the midwifery service; it was a victim of the larger, seemingly insurmountable problems of health care provision in the Jim Crow South. The systemic racism woven deeply into the fabric of southern society created an environment almost totally devoid of adequate educational opportunities for black nurses, not to mention black physicians. African American nurses when appropriately qualified found it difficult to overcome the disadvantages of being paid lower wages than white nurses, openly discriminated against in the workplace because of racial bias, and having to accept restrictions on housing and social activities due to segregation. These problems were only magnified for nurses at the supervisory level.¹⁴¹

The macro-conditions of health care provision largely avoided by lay midwives were confronted head-on by nurse-midwives functioning within the larger medical community. As an integral part of a professional inter-disciplinary and interracial team, the endemic discrimination they faced was intolerable to many. The problem of recruitment and retention of high-caliber African American nurses in the South had long

¹⁴⁰ Ettinger, 151.

¹⁴¹ Estelle G. Massey, "Sources of Supply of Negro Health Personnel," *The Journal of Negro Education*, Vol.6 (1937), 483-492, in ed. Hine, *Black Women in the Nursing Profession*, 103-111; *Canty* 34.

been identified by the National Organization of Public Health Nursing. A 1930 survey showed “a remarkable unanimity against accepting southern positions until conditions improve materially.” The same publication put forth that northern nurses could not adapt to the “southern psychology”, and southern nurses having completed advanced training in the North could not then revert back to the professional and social deprivations of the South.¹⁴²

The Maternity Center Association determined the problem of retention as a significant factor in the demise of the school of nurse-midwifery at Tuskegee. During the five years of operation, three nurse-midwives held the position of director, each resigning after a short tenure. Three nurse-midwife instructors, all graduates of the MCA, resigned in 1942 citing that they were “all deeply interested in the program, but they could not afford to continue working under the unfair living and working conditions.”¹⁴³ In an oral interview, 1944 graduate of the school Nettie B. Jones reinforced this sentiment. After graduating, she worked as a nurse-midwife at the Macon County Health Department and although she thoroughly enjoyed the work her salary, which was lower than that of white nurses, did not meet her financial needs.¹⁴⁴

The lack of support from the Tuskegee Institute and John A. Andrew Memorial Hospital listed as a reason for the failure of the nurse-midwifery training program, reflects the ambivalence towards nurse-midwifery within the black medical community. It has been argued that the promotion of midwifery even at a professional level perpetuated a “racial dualism” in maternal health care that was used to advantage by southern state

¹⁴² Stanley Rayfield, “A Study of Negro Public Health Nursing,” *The Public Health Nurse*, (October, 1930), 525-536, in Ed. Hine *Black Women in the Nursing Profession*, 71.

¹⁴³ Maternity Center Association, 61.

¹⁴⁴ Canty, 34.

boards of health.¹⁴⁵ Black physicians with the help of federal funding allocated by New Deal policies pushed for a physician-centered, more mainstream health care system in the South. Although a welcomed intervention that modernized treatment and expanded hospital care, this approach towards maternal care solidified the concept of childbirth as a medical crisis, one that required the skills and scientific expertise of a doctor. The wartime Emergency Maternal and Infant Care program (EMIC) underscored the value of hospitalized childbirth and despite the fact that poor, rural black women remained underserved by physicians and hospital facilities, attitudes had begun to change.

Beneath an over-arching narrative of racism, for some African American women going to hospital became a marker of status; a midwife delivery was seen as an indication of exclusion, poverty and backwardness, a hospital delivery a sign of inclusion within a larger, modern and “scientific” society. Anthropologist Gertrude Jacinta Fraser argues that the pejorative racial stereotyping of midwifery effectively blocked any possibility of a professional role within the South’s medical hierarchy.¹⁴⁶

The historical analysis of the role of African American nurse-midwife from a micro-macro perspective reveals an approach to maternal healthcare that reflects current programs designed to promote better healthcare access for African American women. Skills of cultural competency are again considered to be essential in enhancing the quality of care, and the dissemination of knowledge via community leaders has proven to

¹⁴⁵ Bruce Bellingham and Mary Pugh Mathis, “Race, Citizenship, and the Bioethics of the Maternalist Welfare State: “Traditional” Midwifery in the American South under the Sheppard-Towner Act, 1921-29,” *Social Politics*, Vol 1, No. 2, (1994), 158-159, 173 in Hill, 84.

¹⁴⁶ Gertrude, Jacinta Fraser, *African American Midwifery in the South; Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998), 103.

be effective in recent federally overseen projects.¹⁴⁷ However, within the context of the Jim Crow South, access into a strengthening system of federal healthcare was seen as a crucial step in the campaign for civil rights. Micro considerations of care were subsumed by a macro level federal system that was perceived to employ fewer discriminatory practices and provided some degree of equality of care.

¹⁴⁷ Collins O. Airhihenbuwa and Leandris Liburd, "Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender, and Power," in *Health Education and Behavior*, Vol. 33, No. 4 (August, 2006), 488-501.

Chapter 4

Changing Attitudes and Better Access, 1920-1970

Ironically, as early as 1966 some doctors in the South were lamenting the state of maternity care. That year in an article in the *Virginia Medical Monthly*, the exasperated Dr. Gordon Jones complained that, in “one month [he had] delivered twenty of these [poor, black] women he had never seen before, most of whom just dropped into the emergency room in labor, without having had any pre-natal care.”¹⁴⁸ The medical establishment had been successful in its goal to transform women’s perception of childbirth from a physiological process to a pathological one requiring scientific intervention at birth. The prevailing Western model of physician-led mainstream medicine superseded culturally aware practitioners whose authority was rooted in tradition and community. Political and activist influences from inside and outside the South forced the creation of a medical infrastructure that brought modern, scientific care to within reach of the majority in the region. The development of a hospital system that would cater to all was fraught with impediments grounded in racial discrimination and economic deprivation. However, the gradual inclusion of African American physicians into the professional medical body and strength of federal mandates ultimately resulted in an expanding network of medical facilities and services. There can be no doubt of the enormous health benefits that accompanied this transition, or of the highest intentions of those instrumental in ensuring that the most vulnerable in society, both black and white, had access to modern health care.

¹⁴⁸ Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth Race and Memory* (Cambridge: Harvard University Press, 1998), 134.

Yet the prevailing theory that held sway during the mid-decades of the twentieth century was that medicine was a metaphor for progress. Huge strides were made in all aspects of medical research and with the expansion of knowledge and technology, hospitals became the center of practice, doctors became specialists instead of generalists, and personal attention was replaced by a specific treatment. These macro components of health care reigned supreme over the individualized, trusted, and familiar components of micro level care that functioned at the community level. It is unreasonable and clearly absurd to argue against the value of macro level care, and yet applying a micro/macro approach does reveal its inadequacy, and accepting that culture and community play a role in good health is crucial for the delivery of acceptable care. An analysis of the trajectory of maternity care in the South lends itself to this approach as change, although delayed in comparison to the nation as a whole, was rapid and decisive when it eventually occurred. However, it can be argued that these changes occurred generally, but not always in the direction of improvement.

Unraveling the complex web of obstacles that prevented African Americans in the South from accessing physician-led and hospital-based care necessitates going back before the development of the nurse-midwives, discussed in Chapter Two, and of course well before the movement to general acceptance of medicalized childbirth, the focus of much of this chapter. Indeed, since emancipation, an assortment of issues interacted with each other to create the intractable problems associated with African American childbirth. However, in the final analysis racial, cultural, economic, and geographic factors inhibited African Americans from seeking medical care even if or when facilities were available.

In light of high rates of mortality among African Americans in the South prior to the 1960s, it is perhaps not surprising that southern black culture had developed a

persistent trait of fatalism when it concerned illness. Folk remedies were employed when necessary, but denial of illness was reinforced by family or community pressure in order to fulfill obligations and responsibilities rather than play the “sick role.”¹⁴⁹ Even when in dire need, black people were reluctant to seek medical attention for a number of reasons. If a hospital was geographically accessible it was unlikely to treat African Americans. As late as 1930, twenty of South Carolina’s forty-six counties were without any hospital, and few, if any, of those that did exist admitted black patients. If a white doctor did condescend to see them there was a wide belief that they would be used for experimentation, and if they did receive treatment the segregated black wards of hospitals were far beneath the minimum standards of the day in terms of cleanliness, care, and equipment. Added to this was the question of payment; medical fees were typically beyond the reach of the average black family. The experience of George Brown, a sharecropper in South Carolina was commonplace. He never took any of his children to a doctor until one of them became “desperately ill.” The nearest doctor was eighteen miles away and across a bridgeless waterway. The fee for medical service was five dollars, an amount far above Mr. Brown’s budget.¹⁵⁰ All in all, hospital care and medical expertise was simply not an expectation of southern African Americans, and it was largely unsought.

Policymakers and leaders of the black medical profession who hoped to solve this problem clearly had many issues to address. Two of the most obvious approaches included the training and professional development of African American physicians, and the funding and support of hospitals that cared for the black population. Succeeding on

¹⁴⁹ Edward H. Beardsley, *A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South* (Knoxville: The University of Tennessee Press, 1987), 34.

¹⁵⁰ Beardsley, 36.

dismantling these two mutually dependent problems was as important as it was difficult, since both required confronting institutionalized racism.

Black physicians in the South were “virtual prisoners of American racism and the segregationist structures it spawned.”¹⁵¹ At every turn their ability to practice medicine was curtailed. To begin with the number of places open to African American medical students was limited. Some white schools in the North and West used a quota system for accepting black students; the 1932 class at the University of Michigan was notable in that it included four black graduates, more than usual. Two large medical schools in the South, Howard and Meharry, graduated more than one hundred African American physicians each year, but both of these black institutions struggled against the discriminatory laws and practices of the region. Inadequate funding resulted in poorly equipped, antiquated facilities and the sub-standard education level of many entering students caused the failure rate at the national board exams to be higher than average. One effect of this failure rate was to instill a sense of deficiency among those associated with the schools. As one graduate of Howard lamented, “we are daily made to feel that our diploma represents less and less in terms of solid, scientific medical training.”¹⁵²

Upon entering the medical profession African American doctors were severely limited in their options for specialized professional training and development. They were largely excluded from internships and residency programs at accredited hospitals and, furthermore, many black physicians were unable to gain membership to the American Medical Association (AMA). In order to join the AMA, a doctor had to be accepted by a local state or county medical society but in the South the societies excluded black doctors until the 1950s. Further compounding the problematic situation for black physicians was

¹⁵¹ *Ibid*, 77.

¹⁵² *Ibid*, 78.

that many hospitals' criteria for a staff position included membership in the AMA or local affiliate.¹⁵³ Frustrated doctors committed to improving health care in the South argued that, "it is impossible for a Negro surgeon to keep himself in good standing with the American College of Surgeons in the South, where local medical associations refuse to admit him to membership and accredited hospitals deny him affiliation."¹⁵⁴ As late as 1960, Dr. Helen Barnes, an African American physician beginning her career in Mississippi, was unaware of a law prohibiting black doctors from taking care of white patients. The Citizens' Council threatened action against her and her white patients should she persist in violating the law.¹⁵⁵

At the turn of the twentieth century, as the medical profession became more scientific and standardized, racism within the structure of medical practice intensified. Seeing little hope in making broad policy changes, the small but determined body of black physicians looked to themselves and their communities. African American physicians had established the National Medical Association (NMA) in opposition to the AMA in 1895. However, in 1923 amid growing concerns about the effects of the standardization programs of the AMA, the National Hospital Association (NHA) was created. Operating under the direction of the NMA, the NHA's objective was to support and maintain proper standards of education and efficiency in black hospitals. These two organizations are responsible for the survival of the black medical profession beyond the Jim Crow era. The NMA and its associated journals and conferences provided an arena

¹⁵³ Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (Oxford: Oxford University Press, 1995), 29.

¹⁵⁴ Michael M. Davis and Hugh H. Smythe, "Providing Adequate Health Service to Negroes," *The Journal of Negro Education*, Vol. 18, No. 3, The Health Status and Health Education of Negroes in the United States, (summer, 1949), 310.

¹⁵⁵ Dr. Helen Barnes, interview by Jenny Luke, Jackson, Mississippi, December 29th, 2012.

in which to fight the battle for integration of the profession and health services. By providing an environment in which black doctors could gain clinical experience and training, the black hospitals and the NHA filled a crucial void in the provision of health care.¹⁵⁶

Black patients were primarily cared for in all-black hospitals. However, in sixteen southern states, 9.7 million African Americans were served by 79 black hospitals most of which were unaccredited, under-equipped, and struggling to stay open as the financial constraints of serving an economically deprived community ensured uncertain survival.

¹⁵⁷ White philanthropic organizations such as the Rockefeller Foundation, the Julius Rosenwald Fund, and the Duke Endowment undoubtedly undergirded the black hospitals' fiscal stability, thus improving health services, but restrictions attached to the availability of funds created political and professional animosity within the ranks of the black medical profession.¹⁵⁸

One divisive issue facing those who hoped to solve the problem was the pervasive debate on segregation versus integration of health services. Paradoxically, the promoters of black hospitals viewed the segregated institutions as the only sensible strategy to gain a foothold in organized medicine and eventual professional acceptance and integration. But by creating and accepting separate institutions, they appeared to be condoning what was later referred to as "deluxe Jim Crow".¹⁵⁹ New Deal relief funds culminating in the 1935 Social Security Act stimulated the improvement of public health in terms of personnel and services, particularly in maternal and infant care, and later in

¹⁵⁶ Gamble, 35-36; Beardsley, 82

¹⁵⁷ Karen Kruse Thomas, "The Hill-Burton Act and Civil Rights: Expanding Hospital Care for Black Southerners," 1939-1960, *The Journal of Southern History*, Vol. 72, No. 4 (Nov., 2006), 826.

¹⁵⁸ Beardsley, 90-100.

¹⁵⁹ Gamble, 56.

1946, the Hill-Burton Act that underwrote the construction of a modern health care infrastructure, created almost a half million hospital beds across the nation.

Unfortunately, the Act took an ambivalent stance on hospital segregation. It dictated that facilities built using Hill-Burton funds must not discriminate on race, but in those states where separate hospital facilities already existed for separate population groups, the non-discrimination mandate could be ignored providing they “supplied blacks with enough facilities and services of like quality to meet assessed needs.”¹⁶⁰

Hill-Burton’s impact on the South was to spread the macro dimensions of health care in the form of modern, hospital-based care, albeit in segregated facilities, across the region. Much investment was made in large teaching hospitals that in turn fostered the growth of institution-based, capital- and technology-intensive medicine. Such facilities served the urban poor as well acting as tertiary care centers for rural patients, but the typical Hill-Burton project was a small hospital with fewer than fifty beds, operating in a community of fewer than five thousand. Access to macro elements of care began to alter expectations and attitudes towards health care. However, if southern African Americans benefited from Hill-Burton, the same could not be said for black physicians who continued to be denied professional privileges at most hospitals until full integration was achieved in the mid 1960s.¹⁶¹

After desegregation of medical facilities had thoroughly spelled the demise of black hospitals unable to compete with better-funded integrated institutions, scholars and activists have revisited the value of former system. In recent years African Americans especially have begun to reassess the value of black-controlled institutions for many of

¹⁶⁰ Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954* (Athens: University of Georgia Press, 2011); Beardsley, 178.

¹⁶¹ Kruse, *Deluxe Jim Crow*, 176-181; Beardsley, 156-185.

the same reasons, and with a similar approach to the analysis of maternity care in this study. Supporters and historians of black hospitals have focused on the very positive and persistent qualities of African American communities, such as local community organization, the strength of community leaders, collective identity, and self-reliance.

The experience of one black hospital suggests that present-day supporters are not wrong about their value. The Slossfield Community Health Center in Birmingham, Alabama, illustrates the potential of a hospital of this type, one that blends micro and macro elements of health care, today considered so desirable in the provision of good service. In 1937, a grassroots movement established Slossfield to improve community health, and those organizers took a broad view of health centered on “wellness”. Their hospital met general medical needs, and addressed three specific areas in its community’s health: maternity care, venereal disease care, and TB treatment. Beyond this, the institution fulfilled the macro health care needs by being “unique in the idea and practice of extending graduate medical training to Negro physicians.”¹⁶² Slossfield was the only busy maternity hospital available for obstetric training, and took its commitment to black professional medicine seriously. In 1940, the hospital opened a conference room to the local black medical association for their monthly meetings where post-graduate education was offered.

At the micro level, Slossfield’s holistic approach to wellness connected good health to adequate housing, control of poverty, and effective support networks. To achieve these goals each patient was initially interviewed by a medical social worker; housing was assessed, as was employment and income; if the patient was unemployed,

¹⁶² Walter H. Maddux, M.D., “The Slossfield Health Center: An Example of Local Medical Service for Mothers and Children Under the Public Health Auspices,” *American Journal of Public Health*, (May, 1941), Vol. 31, 485.

job training or education was made available, childcare was arranged when necessary.¹⁶³ Furthermore, outreach health education programs were systematic and effective resulting in the community becoming “increasingly aware of ill health in members of the family before disease reaches an advanced stage” and voluntarily seeking advice and treatment before hospitalization was required.¹⁶⁴ This change in attitude was important in fostering an expectation and demand for an adequate standard of care.

The community initially funded Slossfield; local workers elected to have money withheld from their pay, and a grant was established on the death of a local business owner. Local funds were supplemented by the Julius Rosenwald Fund and by a small grant from the Works Progress Administration.¹⁶⁵ As Jennifer Nelson argues though, the increasing federal support for Slossfield beginning in the mid-1940s with monies from the Children’s Bureau in the form of the Emergency Maternal and Infant Care Program (EMIC) came with a price.¹⁶⁶ Mandates forced a shift away from an expanded vision of well-being and community health towards a narrower mainstream emphasis on macro level health care, in particular of maternity care. However, it is important to note that community leaders and members of the governing board of Slossfield largely welcomed federal intervention because of their experience with intense racial discrimination in private and local public health services. Of particular relevance to this study, Nelson claims that when given the option to use modern medical services, black women took it:

¹⁶³ Jennifer Nelson, “Healthcare reconsidered: “Forging Community Wellness among African Americans in the South,” *The Bulletin of the History of Medicine*, 81.3 (2007), 594-624.

¹⁶⁴ Maddux, 485.

¹⁶⁵ Nelson, 603, 604,

¹⁶⁶ *Ibid*, 615.

in Alabama, by 1950 approximately 50 percent of African American women gave birth in a hospital (among whites, this figure was 95 percent).¹⁶⁷

As a trend then, for African American women in the South, maternity care made a rapid transition from home to hospital, from micro to macro-focused. However, before hospitals such as Slossfield welcomed large numbers of expectant mothers, medicalization occurred. Although only one percent of the 1750 female admissions to a black hospital in Yazoo City, Mississippi, between 1931 and 1935, required obstetric expertise, maternity care was changing.¹⁶⁸ Women continued to have midwife deliveries at home, but increasingly they had some institutional health care. As midwifery licensing requirements tightened and required a clinical pre-natal examination, that clinic visit became the entry point to macro health care. James Ferguson commended Mississippi midwives' successes in this regard and, in South Carolina, 90 percent of expectant black women in some counties were "given the privilege and benefit of a medical examination" by 1940.¹⁶⁹ In Georgia and the Carolinas, by 1950 the number of black women seen in maternity clinics was about fifteen times greater than the number of white; the clinics, like midwifery, became identified as a "colored institution." More significantly, however, access to the clinics resulted in a change in the expectation and attitude of African Americans. They began to accept the importance of early and consistent prenatal care,

¹⁶⁷ Ibid, 606.

¹⁶⁸ David T. Beito and Linda Royster Beito, "'Let Down your Bucket Where you are': The Afro-American Hospital and Black Health Care in Mississippi, 1924-1966," *Social Science History*, 30, No. 4 (Winter, 2006): 558-559.

¹⁶⁹ Karen Kruse Thomas, *Deluxe Jim Crow*, 86.

and placed a higher value on professional medical attention and medical authoritative knowledge.¹⁷⁰

Not only did the clinics provide initial access to modern and scientific, in other words macro health care for black women, it was often the first contact that the predominantly white public health workers had with poor rural African American women. Stereotypical assumptions based on race were intensified by biases of gender and class creating a macro-care experience that was less than satisfactory. Racism countered what was ostensibly an advancement in health care. In the late 1930s Paul Cornely, a black activist and physician, assessed health services in the South for the Rosenwald Fund and observed that, “Negro patients were often treated with condescension, lack of sympathy, without respect and dignity, and without attention to many of the minor details for personal comfort and privacy.”¹⁷¹ Attendance at the clinics by lay midwives went some way to mitigate these issues, smoothing out the transition between micro and macro spheres of care, as did the presence of black nurse midwives and public health nurses.

In her anthropological study of a rural African American community in Virginia, Gertrude Jacinta Fraser suggests that placing blame onto women who had received no pre-natal care was a racially motivated way for physicians to excuse themselves in cases of medical neglect. A 1942 commission to investigate maternal mortality in Virginia’s state hospitals generally classified African American maternal deaths as “a preventable obstetric death because of the absence of pre-natal care and the failure to seek medical help in a timely fashion. These failures were due to neglect or ignorance on the part of

¹⁷⁰ James H. Ferguson, “Mississippi Midwives,” *The Journal of the History of Medicine*, (Winter, 1950): 89; Thomas, *Deluxe Jim Crow*, 60, 86; Beardsley, 277.

¹⁷¹ Karen Kruse Thomas, *Deluxe Jim Crow*, 89; Beardsley 93,94. See part 1 for more information on the midwives’ role in pre-natal clinics and part 2 for more on African American public health nurses.

the patient and her family.”¹⁷² Other evidence confirms that white policymakers seemed to assume black women did not get needed prenatal care because they were indifferent to pregnancy, rather than access to care. A 1941 medical journal published an article claiming that many black mothers “don’t care and in many cases are glad when the baby doesn’t live.” Showing a clear lack of cultural awareness, the article was critical of the fatalistic attitude held by many women towards their pregnancy.¹⁷³ Some black physicians and public health nurses may have also struggled to overcome their own classist views on the poor and hopeless.¹⁷⁴ In the realm of macro healthcare, the relationships between practitioner and patient were less than optimal. The social distance between the two allowed the intervention of prevailing negative assumptions of race, class, and gender as well as an ignorance of culturally specific motifs and attitudes. Nonetheless in the years before hospitals became widely accessible, black expectant mothers flocked into maternity clinics during the 1940s and 50s eagerly accessing a more modern, scientific approach to childbirth. In a region with little or no public transportation, those without access to a car simply walked to clinic.¹⁷⁵

As hospitals expanded, problems arose in the physical standards of maternity care. Some rural physicians argued that the home, under the supervision of well-trained and capable lay midwives, was a safer, more sanitary environment for delivery given the appalling standards of cleanliness found in black wards and hospitals. African American obstetrician-gynecologist Andrew Best described conditions for black mothers and infants at Pitt County Memorial Hospital in Greenville, North Carolina. From the time he arrived there in 1954 until the mid 1960s, all black women were hospitalized on the same floor.

¹⁷² Fraser, 133.

¹⁷³ Beardsley, 99; Thomas, *Deluxe Jim Crow*, 89.

¹⁷⁴ Beardsley, 98,99.

¹⁷⁵ Dr. Helen Barnes, interview, December 29th, 2012.

He recalled, “whether you had pneumonia or a newborn baby, you were on the so-called colored floor.”¹⁷⁶ Dr. Helen Barnes remembers a similar scenario from her early practice in Mississippi.¹⁷⁷ As an obstetric nurse, Faith Gibson worked in a segregated facility and described the procedure for an African American woman in labor. Because the labor ward was all white, black women were admitted to a general floor that could place her next to a woman with gallstones or a diabetic woman with a gangrenous foot. When delivery was imminent, the nurse whisked the women up to the delivery room, but inevitably many women delivered in the elevator without medical attention, privacy, or dignity.¹⁷⁸

Even when maternity beds were specifically designated as such, conditions were little better. Complaints about a “Negro maternity ward” were published in *The Chicago Defender*. At the John Gaston Hospital in Memphis “a criminal lack of sanitation and wholly inadequate facilities” was reported in 1944. Trash-littered floors, standing water and flies were commonplace, and the “newborns lying in box-like receptacles were wheeled about on unpainted, grimey wooden carts.”¹⁷⁹ St. Martin de Porres Hospital in Mobile, Alabama, opened in 1941 to serve the African American community but only had four maternity beds until it was later expanded to a 35-bed capacity. Only in the 1950s then, did it provide for the first time an opportunity for black physicians to treat their

¹⁷⁶ Thomas, *Deluxe Jim Crow*, 82.

¹⁷⁷ Dr. Helen Barnes, interview Jenny Luke, Jackson, Mississippi, December 29th, 2012.

¹⁷⁸ Penfield Chester, *Sisters on a Journey: Portraits of American Midwives* (New Brunswick: Rutgers University Press, 1997), 139.

¹⁷⁹ *The Chicago Defender (National Edition)*, “Memphis Babies Born in Unsanitary Wards”, August 19, 1944. ProQuest Historical Newspapers: Chicago Defender (1910-1975).

patients with “the aid of the diagnostic and therapeutic facilities of the modern hospital.”¹⁸⁰

What constituted a typical maternity care regime at the newly built facilities across the South is difficult to accurately assess. Certainly, by the 1950s the expectations associated with childbirth for most urban women, black and white, included effective pain-relief and a medically managed labor and delivery that was conducted in a modern, clean hospital. For many African American women, access to scientific medicine and the macro health care system represented an entre into American society at large and brought with it the hope for positive change. By distancing themselves from the negative imagery of midwifery and its associated poverty, black women put their maternal health in the hands of doctors and accepted the “appropriateness” of hospitalized childbirth as a better way to do things.¹⁸¹ Although the number of black maternal deaths remained higher than that of white women, maternal mortality fell dramatically.¹⁸² However, this cannot be entirely attributed to hospitalized childbirth since it was also a period of greatly improved pre-natal care and midwifery standardization. Effective antibiotic therapy, emerging in the post-war era, was also critically instrumental in lowering mortality.

Despite being accepted as safer, modern, and proper, scientific childbirth was reported to be highly unsatisfactory for women. Modern efficiency and sterility were equated to a regimentation and procedure that was reflected in the nursing care during labor. Nurses were described as callous and brutal since they were the most visible agents of the strange and frightening routines imposed on women in labor. In a robotic,

¹⁸⁰ Sister Maria, R. S.M., “History of the Saint Martin de Porres Hospital, Mobile Alabama,” *Journal of the National Medical Association*, July 1964, Vol. 56, No.4, 305.

¹⁸¹ Fraser, 130-136.

¹⁸² Beardsley, 279.

mechanized way they separated a woman from her family, restricted all fluids, gave her enemas, shaved and swabbed her pudenda, and administered analgesic and amnesic drugs rendering the women incapacitated and wholly unaware of the birth of her infant.¹⁸³

Joselyn Bacon, a certified nurse midwife working in Mississippi recalls the common assumption that obstetric nurses and doctors were “mean.”¹⁸⁴ Women who had experienced both styles of delivery, although appreciative of the availability of hospital and obstetricians, lamented the loss of personal, caring, and understanding treatment. A patient of Claudine Curry Smith’s commented:

The midwife was always right there and they was smoothing your hands and talking you. In hospital they laid you up on a table and nobody came in to see you until they think you probably ready for delivery. They put that cold stuff on you. They won’t say nothing to ease your pain. The midwife stayed with you and held your hand and rub your forehead. It was comforting. They was interested and they was concerned.¹⁸⁵

The presence of a trusted practitioner was noticeably absent.

Apart from the lack of personal attention, access to macro-level care did not even solve all the macro-level health problems for African American women. Not surprisingly, black women did not receive the same level of care as white women, even in a model of care that was impersonal and mechanized. According to obstetric nurse, Faith Gibson, laboring black women remained on the general floor throughout the first stage of labor and, because they were not constantly observed by nurses, could not receive any pain

¹⁸³ Margarete Sandelowski, *Pain, Pleasure, and American Childbirth: From the Twilight Sleep to the Read Method, 1914-196* (Westport: Greenwood Press, 1984), 61-70.

¹⁸⁴ Joselyn Bacon, interview Jenny Luke, Jackson, Mississippi, December 29th, 2012.

¹⁸⁵ Claudine Curry Smith, 117.

relief. She also acknowledged the prevailing racist assumption that black women, as primitive and animal-like beings, did not have the same capacity to feel pain as white women.¹⁸⁶ Despite the downward trend of maternal deaths, black women continued to experience a death rate following caesarian section that was four times higher than that of white women.¹⁸⁷

Moreover, as modern hospital facilities sprang up across the South under the auspices of the Hill-Burton Act, hospital care lay beyond the financial reach of many African Americans. Beardsley describes two very separate Southern black populations to emerge after 1945; one increasingly urban, lying within the reach of public health agencies and private physicians; the other comprising of 35 to 40 percent of the whole who lived almost entirely out of the existing health and medical systems, isolated in impoverishment. The improving maternal and infant mortality rates that were largely seen in the first group gave some reformers cause for optimism, but masked the true deprivation of the second group, a truth that was not revealed until the late 1960s.¹⁸⁸ The correlation between poverty and ill health was widely accepted, and yet institutionalized racism prevented the allocation of the much needed funds when it came to black health care. A powerful physician opposition to anything but a fee-for-service system resulted in many, black or white, being excluded on economic grounds until the passage of the Medicare in 1965, but not implemented in most southern states until 1969 and 1970. In 1949, Michael M. Davis, the chairman of the Committee on Research in Medical Economics argued for a national health insurance system that would allow poor people access to adequate health care. Using figures published by the American Medical Association he claimed that 120,000,000 Americans in 1947 earned below the minimum

¹⁸⁶ Chester, 139.

¹⁸⁷ Fraser, 131.

¹⁸⁸ Beardsley, 273-282.

income of \$5000 per annum required to cover the addition costs of medical care. More specifically, 75 percent of African Americans lived in states where the per capita income was \$1000 or less, Mississippi registering a per capita income of \$555 in 1946.¹⁸⁹ These figures put into clear perspective the harsh reality of modern health care access in the South.

However, despite the shortfalls in care and problems of affordability African American women across the region became accustomed to delivering their children in hospital. In the post-war period, changing attitudes, improved access, increased acquisition of knowledge and education, as well as a reduction in the number of lay midwives all contributed to the shift. Again an analysis of micro and macro elements of healthcare is helpful in unraveling the subtle triggers of this shift. The situation in South Carolina highlights the important relationship between expectation and cultural change. In that state, beginning in 1940, the state board of health implemented and developed a sophisticated, efficient, and thorough program of lay midwife training, licensing, and supervision.¹⁹⁰ The successes of which were reflected in a dramatic improvement in infant and maternal mortality rates. And yet, although women were receiving a greatly improved standard of maternity care, within a model of care envied by other states, the shift into hospital was still decisive. According to government issued statistics, in 1949 60 percent of black women in South Carolina were delivered by a midwife, and significantly, given the level of state oversight, it can be assumed the midwife was a licensed practitioner functioning in a multi-disciplinary structure. However, by 1969, 90 percent of

¹⁸⁹ Michael M. Davis and Hugh H. Smythe, "Providing Adequate Health Services to Negroes," in *The Journal of Negro Education*, Vol. 18, No. 3, The Health Status and Health Education of Negroes in the United States, (Summer, 1949), 305-317.

¹⁹⁰ For more on this program see chapter 2

black women had a physician delivery in hospital. Women did not turn to hospital delivery simply because they assumed it was safer. In fact, in Alabama state records reveal a higher non-white infant mortality rate higher in 1964 than in 1955.¹⁹¹ Clearly, the triggers for change were more complex.

Beyond simply having better access to facilities and modern science, changes at the community level, the micro level, have been suggested as deeper explanations for women's shift into hospitals. From her fieldwork with elderly members of a rural African American community in the 1980s, anthropologist Gertrude J. Fraser observed that the actual and symbolic changes surrounding childbirth were largely understood as necessary progress, and the loss of the midwife as an accepted exchange for inclusion in the American health care system. If progress and inclusion were associated with scientific knowledge and medicalization, then previously held perceptions of health, illness and treatment had to be dismantled. Modern perceptions were strengthened by the constant accommodations and adjustments that occur within a culture. The elderly women of Green River County interviewed by Fraser believed that medically managed births were more suitable for younger women as there had been a fundamental change in the physical bodies and sensibilities of women. It was assumed that bodies had altered in such a way that they no longer respond to traditional techniques and remedies, and the knowledge and belief of older customs was no longer transmissible from one generation of women to another.¹⁹² Midwife Margaret Charles Smith came to similar a conclusion in her later years observing that "the younger race having babies now don't be what the elder people, the older heads, used to be." She claimed that although some may learn from books, they do not have the capacity to learn how to be self-sufficient; they lacked

¹⁹¹ Margaret Charles Smith, 114. The infant mortality rate reflects the level of pre-natal care.

¹⁹² Fraser, 166-167.

“motherwit.”¹⁹³ Customs involving a period of seclusion following childbirth eroded, reinforcing the fact that modern bodies were different as women seemingly recovered faster following delivery. It was accepted that scientific knowledge was more appropriate for these modern bodies.

Shifting childbirth customs in the younger generation was also influenced by the diminishing importance of social networks within the community. As the authority of the older generation waned, young women were less inclined to follow the advice of their mothers and grandmothers. Some older women associated some new health issues with the failure to follow old-fashioned practices (unlike those in Fraser’s study). For example, going out too soon after delivery, with or without the baby, was inadvisable. A former client of Claudine Curry Smith commented, “you stayed in the house for a month, not like the girls nowadays that has the baby, come home and they out...don’t even stay in the house. I don’t think it’s a good idea because they’re open and then should be careful lifting and all. But they go around doing the same thing they been doing before they had the babies which is not good.”¹⁹⁴ Young women listened to advice given by older female relatives concerning diet, post-partum behavior, or infant feeding, but rarely followed it.¹⁹⁵

By the late 1960s the implementation of Medicaid in the South ensured the certain demise of the midwives serving poor black women as the federal assistance did not cover midwifery care. Many southern states structured their healthcare plans in line with the political and economic philosophies they had maintained throughout; those being, a neglect of their obligations to the federal government, protection of a fee-for-

¹⁹³ Margaret Charles Smith, 155.

¹⁹⁴ Claudine Curry Smith, 114.

¹⁹⁵ Joselyn Bacon, interview, December 29th, 2012.

service medical structure, and a disregard for African Americans and the poor.¹⁹⁶ In South Carolina, Medicaid coverage did not begin until birth, leaving pregnant women to arrange pre-natal care and delivery at their own expense. Public clinics continued to offer care but they reached fewer women by the 1960s as emphasis and funding shifted away from community clinic to hospital. Compounding the problem, maternity clinics, stigmatized as being only for the poor and black, were less attended as women looked to private physicians for care, even those who could ill afford it.¹⁹⁷

The isolation and deprivation of a large population across the South, together with the political and social environment of the region created a unique situation regarding health and health care. In the face of no alternative, African Americans developed culturally appropriate attitudes and expectations towards sickness and health, treatments and practices. In bringing desperately needed modern and scientific care to the South, the micro considerations of care were discarded in the name of progress. For many, this progress was more than access to macro level care, but by extension, represented the inclusion of African Americans into American society at large bringing an equality of access previously denied. In light of the scientific, political, and social context of the region and era, it is difficult to envision any other trajectory for maternity care in the South. However, the reality that many African American women face today must force a closer examination of models of care that existed in the past, ones that are more specifically focused on the motifs of African American culture.

¹⁹⁶ Beardsley, 306.

¹⁹⁷ Nelson, 622; Beardsley, 307.

Chapter 5

Conclusion

The twentieth-century saw a dramatic shift in maternity care in America, the trajectory in the South lagging behind the North. In the South, the trend towards medicalized childbirth was hampered by the political, social, and economic conditions of the region, and created a unique space for African American lay midwifery to persist, and later nurse-midwifery to exist temporarily, before the widespread availability of hospitalized childbirth. The major transitions occurring in the South between 1920 and 1970 can be pictured as a pendulum swing from a model of care restricted to largely micro level components, through a mid-century era bringing some degree of balance, to a heavily macro-focused care.

An analysis of maternity care using this micro-macro approach exposes the role of the midwife during this era as a valuable asset in the provision of good maternity care, and also explores the experiences of African American women as healthcare providers. Moreover, through the louder voices of lay midwives, nurse-midwives, public health nurses, and physicians, the choices and expectations of ordinary childbearing women who tend to remain silent in history, can be understood.

Clearly, the growth of a macro-structured health care system brought essential benefit to the desperately underserved population of the South; it is absurd to argue otherwise. However as an exercise in historical analysis, a case can be made that the dismissal of the value of micro-level aspects of care proved to be ultimately detrimental to the standard of maternity care provided in the region. The juggernaut of scientific hegemony forced into obsolescence a model of care that held intrinsic value. It is inadvisable to approach the history of medicine with the intention of applying modern standards to the attitudes and assumptions of the past. However, no matter how absurd it

may be to argue against the benefits of modern maternity care, it seems equally foolish to not to consider what was lost at the community, micro level, particularly at a time when the maternity care system is again failing black women.

Recognizing the relationship between culture and health has been of enormous importance in developing effective strategies designed to help lessen health disparities related to race. In 1999, REACH 2010, the acronym for Racial and Ethnic Approaches to Community Health by 2010 was launched to address this issue. In African American communities where REACH has been implemented, particularly in the South where distrust of white physicians continues to be prevalent, interaction with health care providers outside of the hierarchical structure of the clinical setting has been instrumental in demystifying the power of physicians creating a more fertile environment for patient education. A REACH sponsored community based grassroots group in Alabama formed a coalition with healthcare professionals, educators, local newspapers, and clergy to aid in the transmission of information about breast and cervical cancer screening.¹⁹⁸

Similar methods of disseminating knowledge were used by nurse-midwives during the mid-twentieth century, and community level involvement in maternity care was a hallmark of their role. Today in areas where services are inadequate, networks of respected local women could help identify the at-risk and together with community based, culturally competent healthcare professionals, become a link to the macro health structure. Convenient pre-natal clinics and childbirth and infant education classes could be held in places of traditional community gatherings—in churches, for example. Having women and nurses or nurse-midwives embedded in the community, visible and trusted,

¹⁹⁸ Collins O. Airhihenbuwa and Leandris Liburd, “Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender and Power,” *Health Education and Behavior*, Vol.3 no. 4,(August 2006), 498.

will encourage attendance at clinic, and provide the crucial access to macro level care. Interestingly, in Jackson, Mississippi, Dr. Helen Barnes, an African American obstetrician and strong proponent of midwifery who supervised lay midwives early in her career, has recently been approached by the University of Mississippi to assist in the proposition of a school of nurse-midwifery there.

As it has consistently done throughout its history, the African American community is again turning inwards and harnessing its specific strengths of female activism, community solidarity, and leadership in order to abate the current deficiency in maternity care. Black women's grassroots organizations such as SisterSong are taking matters into their own hands.¹⁹⁹ Lay midwifery is also increasing its profile among black women. Groups such as the International Center for Traditional Childbearing are reemphasizing community and family networks to raise self-esteem, black awareness, and promote maternal and infant health. But these efforts will only go so far in providing the necessary services required to reduce maternal mortality; a balance must be found between the culturally appropriate and twenty-first century medical expertise.

An assessment of the historical trajectory of maternity care and the historical value of midwifery in the black community suggests that nurse-midwives, functioning in a modern system, could once again form effective bridges between macro structures of care, community leaders, and childbearing women. An additional area of historical study along a broader theme would be an examination of community controlled hospitals that, like Slossfield, offered a broadly defined concept of community wellness. With the maternal mortality rate on the increase in the US, and those particularly at risk being African American women, it seems that there is little to lose by turning to history to

¹⁹⁹ <http://www.sistersong.net>, mission statement, January 13, 2013.

explore models of care, techniques, and treatments that may have been discarded a little too eagerly in the name of progress.

Appendix A
Photographs and Charts

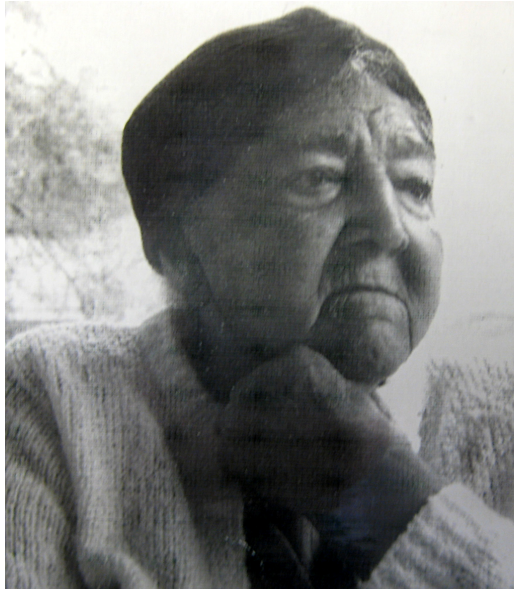


Fig.3. Margaret Charles Smith c.1990 Courtesy of Alabama Women's Hall of Fame.



Fig.4 Lay Midwives, Carroll County, Georgia, 1931. Ad Hoc Collection. Courtesy of Georgia's Virtual Vault.

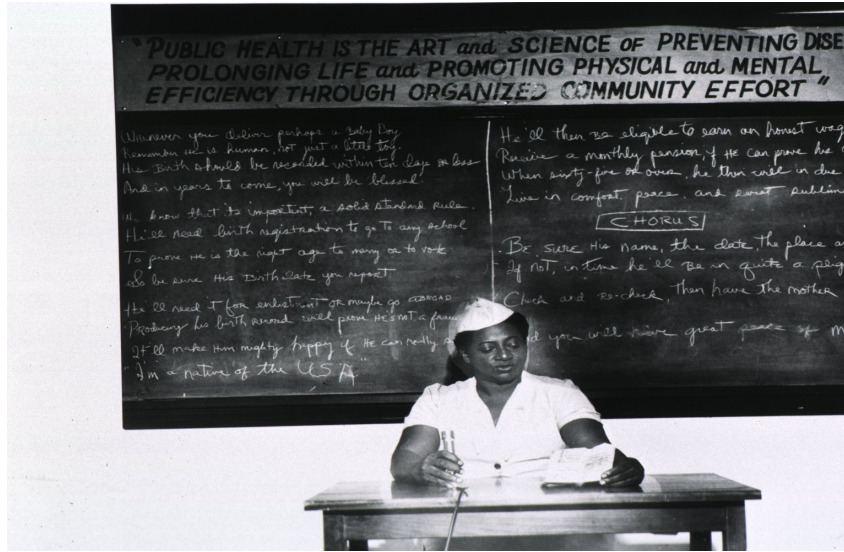


Fig.4. Eugenia Broughton in the classroom. The lyrics to the “Birth Certificate Song” behind her on the blackboard. Photo by E.S. Powell. Collection of the American College of Nurse-Midwives. Courtesy of the National Library of Medicine



Fig.5. Eugenia Broughton teaching a group of lay midwives. Photo by E.S. Powell. Collection of The Images of the History of Medicine. Courtesy of the National Library of Medicine



Fig.6. Maude Callen at work. Courtesy of W. Eugene Smith.



Fig.7. Maude Callen picking her way back to her car, Berkeley County, South Carolina.
Courtesy of W. Eugene Smith.

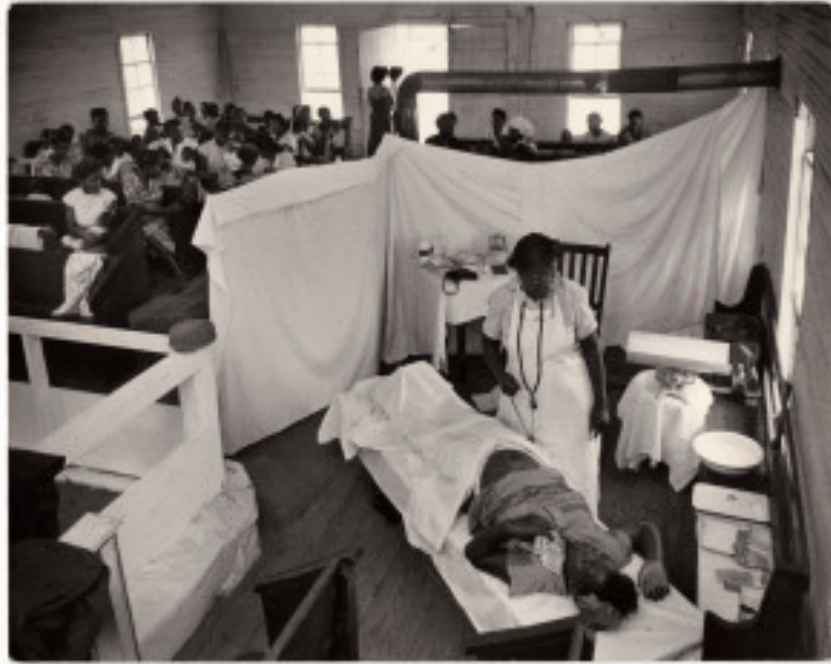
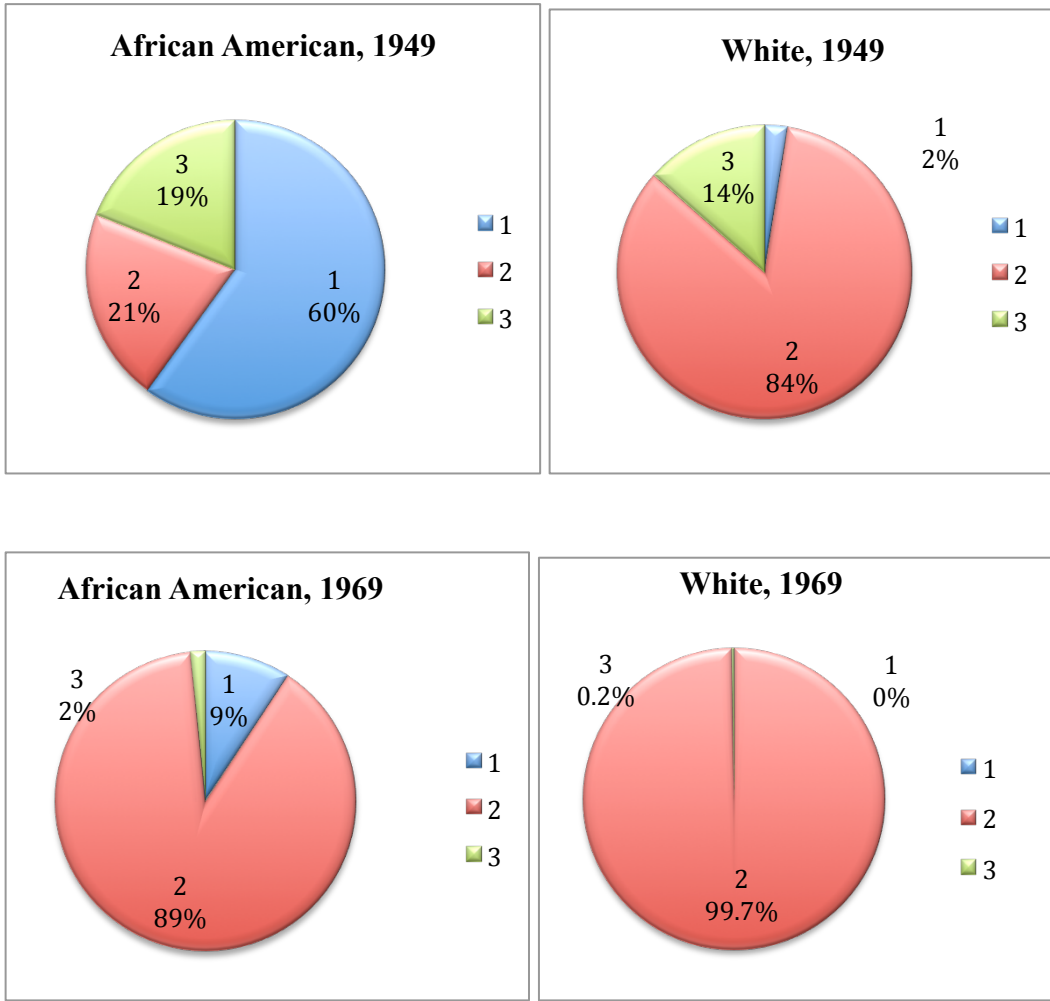


Fig. 1. Maude Callen holding a pre-natal clinic in a church, Berkeley County, South Carolina, 1951. Courtesy of W. Eugene Smith.



Fig.2. A church used as a classroom for training midwives in South Carolina, c. 1940. Photo by E.S. Powell, Collection of the American College of Nurse-Midwives. Courtesy of the National Library of Medicine.

Attendant at Delivery By Race



1-Midwife 2-Physician (Hospital) 3- Physician (Not Hospital)

Fig.8 Attendant at Delivery by Race for South Carolina: 1949 and 1969. (Source: Vital Statistics of the United States, 1949 and 1969.) Courtesy of Edward H. Beardsley.

State	Percentage of women of color with delayed or no pre-natal care	Percentage of women with delayed or no pre-natal care	
Alabama	26.8	16.3	
Arkansas	26.9	18.9	
Florida	21.2	16.1	
Georgia	21.9	15.8	
Louisiana	22.9	15.5	
Mississippi	22.7	15.6	
North Carolina	24.8	15.7	
South Carolina	29.5	20.3	
Tennessee	27.0	16.6	
Texas	22.8	18.9	
Virginia	22.4	14.6	
West Virginia	23.5	14.1	

Fig.7 Maternal Health Care Table. Deadly Delivery: The Maternal Health Care Crisis in the USA. Courtesy of Amnesty International, 2010.

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