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UNIVERSITY OF MIAMI

A STUDY OF AFRICAN AMERICAN LAY MIDWIFERY EXPERIENCES IN RURAL SOUTH CAROLINA 1950-70

By

Joan Sylvia Graham Tilghman

A DISSERTATION

Submitted to the faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Doctor of Philosophy

Coral Gables, Florida

December 2002

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A STUDY OF AFRICAN AMERICAN LAY MIDWIFERY EXPERIENCES IN RURAL SOUTH CAROLINA 1950-70

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A Study of African American Lay Midwifery Experiences in Rural South Carolina 1950-70

Abstract of a dissertation at the University of Miami

Dissertation supervised by Professor Ellen Baer
No. of pages in text (152)

The persistence of lay midwifery in rural South Carolina can be attributed to issues of poverty, segregation and lack of sufficient health care alternatives. In the early twentieth century, the high maternal and infant mortality garnered national attention. Physicians and public health officials identified untrained midwives as a primary cause of high infant and maternal death rates. In an effort to decrease the complications associated with childbirth and decrease the mortality rate, Southern State Boards of Health initiated strategies to improve maternal and infant health. One result of the national attention to increased infant and maternal mortality was the institution of supervision and regulation of lay midwives.

By 1950, "granny" midwives were no longer practicing and lay midwives were required to attend a state Board of Health midwifery training program in order to become certified to practice as a midwife. This study provides a description of midwifery care giving by three African American women who were lay midwives in rural South Carolina between 1950-1970. The women in this study collectively delivered more than 1,000 babies. The women in this study received their training through a state mandated training program for lay midwives which emphasized the science of pregnancy and sought to eliminate any midwifery practices associated with superstition or cultural practices. A historical methodology was used to conduct the study providing for a

critical examination and analysis of past events. The methodology provided the mechanism for gathering, interpreting and analyzing the care giving experiences of lay midwives. The categories identified in the data analysis were: accepting the call, spiritual influences, meeting the standards for midwifery, caring for the pregnant woman, newborn care and community relationships. The significance of the work is that it is based on accounts from African American women who lived the experience and thus are credible to tell the story of lay midwifery care.

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My friends, who are like family, I thank for their support and their encouragement.
I thank Dr. Edna Medford, Professor of History at Howard University, who provided valuable assistance and guidance in helping me to discover resources specific to slavery in the United States. I thank Dr. Robyn Muncy, Professor of History at the University of Maryland, for instilling an enthusiasm and zeal to write about women and history. I thank Dr. Alfred Moss, Professor of History at the University of Maryland, for encouragement and for helping me to appreciate the importance of historical analysis. This dissertation has been a labor of love.

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Call to Midwifery

"I don't know, it just come to me."[1]

> I don't know, it just come to me. I was dreaming about having my own baby. And I just keep on dreaming it. And I just keep on dreaming I was having it. I would wake up at night, and I would say now what in the world is this. And so my sister-in-law say well, the time so tight lets go in for a midwife. I said well all right. We went in for a midwife but after we got there the first year I found out we couldn't get no license. Had to go two years before you could get a license.[2]

Thus, a 78 year-old former lay midwife describes her decision to become a midwife.[3] Her comments symbolize her commitment to pursue an occupation that appears inspired by spiritual influences and economic necessity. This woman became one of many African American lay midwives in South Carolina in the years 1950-1970. This study will explore their life experiences. To avoid confusion, the term African American is used throughout this study to refer to that group of people who have been known as Negroes, African Americans, Africans, slaves and other such names during the time frames examined in this study.[4]

Introduction

Chapter One will provide an introduction to the study by the researcher. Relevant background information will be presented including a discussion of the historical context of midwifery and an introductory overview of African American midwifery. Subsequently, factors that contributed to and influenced health care within the African American community will be identified. Factors addressed include the influence of racial views on African American health care, and access to care. A discussion of the impetus and purpose of the study will follow, with the goals of the study delineated. Next, the

research questions guiding the study will be presented. The chapter will conclude with a discussion of the organization of the remaining chapters and a summary of Chapter One.

Historical Context of Midwifery

Midwifery has existed throughout time, first as a tradition and then as a science-based practice. Midwifery existed in biblical times, in that biblical references attest to the services provided by midwives. In the Old Testament Book of Exodus, the names of two Hebrew midwives are given and the Kings commands to the midwives. The following is an example of such documentation:

> And he said when you do the office of a midwife to the Hebrew women, and see them upon their stools: if it be a son, then ye shall kill him: but if it be a daughter, then she shall live.[5]

In the United States until the 1760s, midwives were the primary birth attendants for women during their labor and delivery.[6] A system of midwifery dating to the early 1400s existed in England that recognized the importance of a midwife as a birth attendant.[7] With the colonization of America, women new to this country brought with them a tradition of serving as birth attendants. In colonial times, women provided companionship to each other during childbirth and assisted with deliveries.[8] Bridgit Lee Fuller, an early midwife in Massachusetts, arrived from England on the Mayflower and more than likely attended the three births that occurred during the journey.[9] A representation of life as a midwife during the early 1700s is depicted in the diary of midwife, Martha Ballard. Her diary recounts life as a midwife during the years 1778-1812 including details of her deliveries of 814 babies and provision of medical services to women living in Hallowell, Maine.[10]

Childbirth has always caused fear and some anxiety. During the 18th and 19th centuries women actively sought comfort and solace from other women during childbirth.[11] In addition, childbirth carried an ominous outcome for many women during the eighteenth century. Nancy Dye conjectured that virtually every woman in the small communities throughout colonial America must have known friends or family members who died or suffered from complications associated with childbirth.[12] Consequently, the primary views and perceptions of childbirth during this period were associated with the fact that it was unpredictable and potentially life threatening. Because childbirth was viewed as dangerous, midwives and attendants assisted at the event. However, even when present and offering their services, midwives did not believe they had consequential control over the birth experience.[13]

At the turn of the twentieth century, approximately one half of all births in the United States were attended by midwives.[14] Because professional schools did not exist for women to receive training in the United States until the 1930s, midwives were more likely to be trained through apprenticeships with a midwife in the community.[15] In the early twentieth century, pregnant women generally chose to deliver at home, in part, due to a lack of hospitals. Prevailing social views considered childbirth a normal occurrence that did not require the assistance of a physician. However, increased public awareness about the possibility of death and physical disability during childbirth caused women to seek safer and less painful means of childbirth.[16]

During the early to middle 1900s, many women began to choose physicians to deliver their babies due to beliefs that a physician could provide a safe delivery.[17] Middle class women sought educated physicians rather than depend on "uneducated persons" to

provide their care during labor and delivery.[18] Increased knowledge about the anatomy and physiology of gestation aided physician arguments that medical practitioners could provide safer and easier childbirth experiences.[19]

Medical advances, such as the use of forceps, aided physicians in delivering babies for which vaginal birth seemed unlikely. The availability of anesthetic agents such as scopolamine, increased technology and the ease of management in well-equipped and well-staffed hospital influenced women's decision to move to the hospital.[20] Dr. Joseph DeLee a prominent obstetrician of the early 20th century proposed the use of forceps as a prophylactic method to minimize births' natural dangers.[21] Beginning in the 1920s the use of prophylactic forceps gained increasing acceptance and use among physicians.[22]

Middle class white women began to make choices to have hospital deliveries to ease their fears of dying in childbirth and to have less painful childbirth experiences. By the 1940s, medicine successfully superseded female midwifery.[23] Midwives, in general, no longer attended the deliveries of middle class women during the twentieth century. However, immigrants, isolated white and African American women continued to seek care from midwives.[24]

African American Midwifery

Wertz & Wertz note that, little is known about childbearing experiences of the African American woman during colonial times.[25] However, accounts of pregnancy and childbirth during slavery exist in historical textbooks and in slave narratives. Slave women apparently brought with them some knowledge of how to assist women during childbirth.

The slave owners frequently decreased the workload for a pregnant slave. A slave that became pregnant might have a reduction in work until the time of delivery; then have to return to the fields three to four weeks later.[26] Most owners excused the pregnant slave from the more strenuous chores during the last months of pregnancy when signs of impending birth became visible.[27] In some extreme instances pregnant slaves did not escape punishment. A pregnant slave might be whipped; and, to prevent harm to the fetus, the pregnant woman would have to lie face down with her abdomen in a dug out hole and be whipped elsewhere on her body.[28]

Depending on the size of the plantation a slave owner might have a hospital or infirmary to treat slaves for illnesses. On some plantations a physician might provide general care to the slaves and would be called to render care for acute or emergency situations. In Georgetown County, South Carolina, a physician Dr. James Sparkman was the regular medical attendant on 25-30 plantations with slave populations of about 3,000.[29] Usually, a female slave became the health care provider for a variety of ills.

In the slave community elderly slaves were significant contributors to the perpetuation of cultural practices and beliefs. On many plantations, an older woman with a diminished ability to work as a laborer became the midwife.[30] After age 50 many slave owners believed the work capacity and monetary values of slaves declined so significantly that the slave would have no value on the slave market.[31] Historian Deborah White notes that by virtue of their greater experience, wisdom and number of children older women commanded the respect of the young.[32]

The definition of elderly is not clear in the literature. Women were frequently called granny or aunt as they became older. Women referred to as granny or aunt were

either middle-aged or elderly and the chances were that they also had children, and many were past childbearing age.[33] Elderly slave women were also viewed as having wisdom and the mental fortitude to be able to assist women in labor. Many midwives received their training from an elder or granny midwife in the slave community, or through an apprenticeship with a physician.[34] Midwives in the slave community were prevalently female, however there were men and women midwives. Ex slave Ferebe Rogers stated:

> course we had doctors in dem days, but we used mostly home made medicines. Course I don't believe in doctors much now. We had men and women midwives. Dr. Cicero Gibson was with me when my first baby come.[35]

Slave women trained as midwives could provide additional income for the slave owner. Records of deliveries were kept because a child born in slavery became the property of the master and could be used for labor or sold for profit.[36] A midwife from one plantation could be hired out by her owner to deliver slave babies at another plantation. Some oral histories of former slaves provide a glimpse into the experiences of being a midwife on a plantation. Former slave descriptions speak of receiving some training early to become a midwife:

> When I was 13 years old my ol mistress put me to work wid a physician who learned me how to be a midwife. Dat was 'cause so many women on de plantation was catchin babies. I stayed wid dat doctor, Dr. McGill his name was for 5 years. I got to be good. Got so he'd sit down an' I'd do all the work. When I come home I made a lot of money for old miss. Lots of times didn't sleep regular or git my meals on times. Cause when they call, I always went. Brought as many white as culled children. I's brought lots of 'em an I ain't never lost a case. You know why. It's cause I used my haid. When I'd go in, I'd take a look at de woman, an if it was beyond me, I'd say "Dis a doctor case. Dis ain't no case for a midwife. You git a doctor" An' dey'd have to get one. I'd jes stan' before de lookin' glass an I wouldn't budge. Dey couldn't make me.[37]

This narrative illustrates the commitment of the slave midwife to render care within the realm of her competency. It also reveals an instinctive ability to discern when medical assistance was needed. Midwives were vital to the slave community because they provided care during a time when health care was almost nonexistent for African Americans. After slavery, the importance of midwives in the African American community did not decline because African American women still depended on the midwife.[38]

Beginning in the early 1900s, many white women delivered their babies in a hospital rather than in the home. Hospitals provided what many white middle class women considered to be the safest applications of new technical and scientific methods of birth.[39] From 1930-1960, the rate of hospital births for white middle class women increased from 36.9 percent in 1935 to 96.6 percent in 1960.[40] The majority of African American women in the South continued to deliver at home until the late 1940s.[41] In 1939-1940, a physician attended 19% of African American births in South Carolina compared to 92% of white births.[42]

Few African American women received medical care during pregnancy, and even fewer delivered babies under a physician's care. Lay midwives delivered the majority of African American babies born in South Carolina.[43] Few comprehensive reports or literature sources about experiences of African American midwives exist. Information about lay midwifery in South Carolina focuses on supervision of midwives and the problems of training midwives to provide safe care. However, midwives' experiences as caregivers, their perceptions of training and application of their learning are not included.

Given the paucity of historical information, a study of African American female health care particularly lay midwifery care in South Carolina, presents a great challenge.

Influence of Racial Views on African American Health Care

Historical documents and books provide some first person accounts of African American life in the twentieth century. Historian Idus Newby notes that traditional histories about South Carolina, written by whites from the vantage point of white Carolina give no insight into the experiences of the "black Carolinians."[44] Much of the general history provides only a cursory discussion of African American health care. The literature about female health care and childbirth experiences during slavery is primarily based on oral histories and plantation records. Oral histories by former slaves provide some insight into health care. However, in many of the oral histories, discussion and/or mention of being a midwife is incidental.

Racial biases are often reflected in the documentation of perceptions about the African American woman and her body. During slavery many owners believed that a pregnant slave could withstand laborious tasks without causing harm to themselves or their babies.[45] Such perceptions include the expressed belief of white people that the African American woman endured physical stresses to her body and responded differently to bodily discomforts than white women.[46]

Further evidence of the influence of racial views on African American health care is documented in the perceptions held by white physicians. Until the early twentieth century, most white physicians believed that African Americans were biologically inferior and physiologically different from a white person.[47] Many white physicians thought it hopeless to engage in efforts to preserve African American health.[48] Some

whites thought the rate of African American deaths was due to their inability to resist disease.[49]

Access to Care

The prevalence of racism and politics of segregation constituted additional variables that affected the quality of health care provided to African Americans. Strict segregationist laws excluded African Americans from admittance to a white hospital unless it contained a segregated section.[50] In the South, racism, inferior segregated health facilities, habits of self-treatment, and reluctance to follow white doctors' medical advice contributed to African American health care problems.[51]

In addition, there were few African American physicians to provide care, which influenced the likelihood of increased illness among southern African Americans. Sixty-six African American physicians practiced in South Carolina in 1910.[52] That number did not change significantly for twenty years.[53] By 1950, there were only 70 African American physicians in the state.[54] This was an extremely limited number of providers for an African American population in South Carolina totaling 822,187 the same year.[55]

In March 1950, Dr. Carr McFall, an African American physician practicing in Charleston, spoke at an Executive Committee meeting of the South Carolina Board of Health. He told the assembled members that he chose to return to his home state to practice after graduating medical school.[56] However, as noted by Dr. McFall, there were limited training opportunities in the South for African American physicians, which did little to encourage them to establish practices within the region.[57] The limited number of physicians, a primarily rural population, the persistence of poverty and continued

segregation contributed to poor health outcomes for African Americans in South Carolina.

Call to Midwifery

During the first part of the twentieth century, African American women in the South worked as domestics and farmed to earn a living. The opportunity to become a midwife afforded additional means of income. African American pregnant women had few care options other than from a midwife. The prevalence of the large number of midwives during this period is associated with a community need that existed for their care giving as well as the fact that midwifery provided income for the family. The economic principle of supply and demand for midwifery services prevailed in the rural South because the need for midwifery was extensive; thus, more women could find employment as a midwife.

A midwife had to be ready to respond to the call for her services at any time. She had to be able to reach her patients, whether she had to walk to the woman's home or depend on others for transportation. Some midwives had young children and had to arrange for someone to care for them in their absence. The telephone was not widely available to a household. Only one person in the community might have a telephone. Frequently, the call to go and assist with a birth came from someone who had ridden on a mule, come in a wagon to get the midwife, or sent a message by a neighbor with a car.

Midwives concomitantly used knowledge learned from training and science-based practices to provide care. Midwifery programs sought to eliminate the use of home remedies and any care giving measures not taught in midwifery classes. Measures used by the midwife other than those that were state sanctioned were viewed as superstitious

or based on ignorance. Midwives in rural areas used a variety of techniques and remedies during childbirth. Midwives conformed to scientific methods when they needed to, while still managing to retain their individual identity as care givers.

Impetus for and Purpose of the Study

As described within the overview of relevant background information, there is little documentation of the experiences of lay midwives and of the practice of lay midwifery within the African American community. African American women who attended midwifery-training programs can provide accurate historical accounts of their experiences as caregivers. These personal descriptions of care giving by former lay midwives provide a rich source of historical documentation. However, the number of women available to provide descriptions of their experiences as lay midwives has declined.

The current study will describe the care giving experiences of three women who became midwives in South Carolina between the decades of 1950 and 1970. Due to poverty, segregation, and a limited number of hospitals, African American pregnant women in South Carolina required the services of midwives. The women who became midwives had limited opportunities for employment in the rural communities where they lived. Farming and domestic work were the primary means of employment for many African American women in 1950. Farming provided little income, and domestic work was hard to find in rural communities. Thus, becoming a midwife provided a viable means of obtaining additional income.

The three women who participated in the study collectively delivered more than 1,000 babies by their accounts. At one point, they were under the tutelage of the same

"granny" midwife who evaluated their abilities to deliver babies before recommending them for midwifery training. The women interviewed at the time of the study were ages 78, 85, and 98. Two of the former midwives are widows. All three women attended training together. They continued the tradition of lay midwifery in their communities after a hospital opened in 1950 in Georgetown, South Carolina, which was approximately 35 miles from their rural community.

One of the women interviewed stated she became a midwife because she needed to earn money. According to her:

> My husband was very jealous, and he really got on my nerves. So I said I am going to make my own money. And I thought about it and called my sister in law and asked her let's go be a midwife. She said I don't know I might go. Let me study over it. And in two or three weeks time she said yeah we'd go. So me and my sister in law went together.[58]

The purpose of the study is to provide a reliable and valid historical account of the experiences and practices of African American women who served as midwives. It is an exceptional opportunity to be able to collect personal descriptions of midwifery training and experiences from women who provided care spanning two decades. The women interviewed for this study opted to become midwives for a variety of reasons. Their descriptions of midwifery care are as valued as their motivation to become midwives.

This study will provide documentation of their experiences in order to assist in the further development of more accurate knowledge about midwifery. The voices of the three women who participated in the study have much to offer in further understanding a critical component of the historical traditions of health care in the African American community. Therefore, it is the goal of the study to provide a record of these rich

traditions while there are those present who lived, helped to create and can speak with authority of the experiences of African American midwives.

Study Research Questions

The research questions guiding the study are as follows:

1) What were the personal experiences of midwives within the African American a rural community in South Carolina during the decades of 1950-1970?
2) What factors influenced African American women in their decision to become midwives?
3) What were the training experiences of women who chose to be midwives and how did they feel about such training?
4) What were the experiences of midwives in helping to deliver babies during this time period?
5) What were the nature and types of problems they experienced with some deliveries?

Significance of the Study

Until recently, the historical experiences, roles and contributions of African American women in health care were largely unaccounted for and/or were told in voices other than those who could speak with credibility. The documentation of these women's experiences provides a means to describe and record the contributions of African American women in health care for childbearing women and their families. The important contributions of these women to their communities as health care providers and the esteem accorded them by the community were a vital component of African American health care.

The research also provides the opportunity to document a vital link to understand the perception of African American women who were midwives as to health care needs of childbearing women in their communities and their delivery of health care to African American women during 1950-1970. Additionally, the investigator will help to further document midwifery as an essential component of rural health care during the decades under exploration.

Scope of the Study

The study is focused on the experiences of three African American women who were midwives in South Carolina during 1950-1970. The results cannot be generalized to the experiences of all African American women who may have served as midwives during this time period. The information obtained will be useful for the further development and documentation of a knowledge base by providing an account of the role and contributions made by African American midwives.

Chapter Summary

Within Chapter One, an introduction of the research undertaken was provided. Background information useful for developing a historical perspective of midwifery in the African American community was addressed, as were factors that influenced health care related services to African Americans. This was followed by a discussion as to the impetus, purpose and goals of the study. Research questions guiding the study were presented and the significance and scope of the study were discussed.

Organization of the Study

Within Chapter Two, a literature review relevant to midwifery in the African American community will be provided. Chapter Three will delineate the research

methodology to be used in the study. Within Chapter Four the results will be presented and Chapter Five will discuss the conclusions of the study.

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Chapter Two

Regulation of Midwives

"I didn't want to get in no trouble with the White folks".[1]

Introduction

In this chapter, a review of the literature focuses on the historical context of and influences on midwifery within the United States. Information will be provided, beginning with initial efforts in the early 1900's to regulate the care provided by midwives. This is useful in developing a more in-depth understanding of factors that contributed to the nature and practice of midwifery between 1950 and 1970. The emergence of regulation, maternal and infant mortality rates, physician opposition, mortality rates of midwives and physicians, the position of midwifery proponents, medicalization of childbirth, and governmental initiatives to improve maternal and infant health care will be covered. Subsequently, information regarding public health regulation and supervision of midwives and factors influencing midwifery in South Carolina will be examined. A summary of the findings of the literature review and a discussion of the strength and limitations of the current literature will conclude this chapter.

Regulation of Midwives

In 1919, the South Carolina State Board of Health began to regulate duties and performances of all midwives in the state.[2] Midwives had to adhere to the rules and regulations of the state in order to obtain a midwifery certificate (Appendix 1). Regulatory mechanisms guided the hierarchical control among the state, local physician and county nurse's supervision of the midwife. The Maternal Child Health Division provided supervision and field nurses to teach and train midwives and to conduct

supervisory visits to counties in South Carolina. County health officers had the responsibility of determining which patients could be attended by a midwife.

Midwives knew they had to follow the rules and regulations of the state. As a former midwife said, "I didn't want to get in no trouble with the white folks".[3] Midwives recognized that white officials controlled midwifery practice with rules and regulations. In January 1919, the South Carolina Board of Health adopted an instruction and supervision requirement for midwives in the state.[4] The Code of Laws (1922) enacted by the South Carolina legislature specified the legal requirements for a midwife to obtain a certificate to practice as a midwife.[5]

The Board of Health required midwives to renew certificates annually. Rules and regulations governing their practice were printed on the back of each Midwife Certificate (Appendix 2).[6] Any violation of rules and regulations could result in either a fine not to exceed $100.00 or imprisonment of up to thirty days.[7]

The drive for midwifery regulation developed from concerns of physicians, public health officials, and government officials who cited midwives as the cause of high maternal and infant mortality rates in the United States.[8] During the years 1910-1930, physicians focused discussions on the "midwife problem".[9] There were differing views among physicians as to whether midwifery should continue. Lay midwives such as the women in this study entered a practice that no longer existed in some states.

In 1914, Dr. Fred Taussig presented a paper at the meeting of the National Organization for Public Health Nursing suggesting that the solution to the midwife question was to establish schools of midwifery to which only nurses could apply.[10] In 1925, Mary Breckenridge a nurse-midwife educated in England initiated the Frontier

Nursing Program in Hyden, Kentucky and introduced nurse midwifery to health care in rural areas. She incorporated nurse midwives, educated in England, into the Frontier Nursing Service.[11] Breckenridge, worked with the Kentucky Committee for Mothers and Babies, a precursor to the American College of Nurse Midwives.[12] During the 1930s, two schools for nurse midwives were established, the Lobenstine Midwifery Clinic and School in Harlem in 1931, and the Frontier Graduate School of Midwifery in Hyden, Kentucky in 1939.[13] Some graduates of these two training programs worked in southern states public health programs to teach African American lay midwives how to provide care for a childbearing patient.[14] In the rural south lay midwives, rather than nurse midwives, continued to be the attendants for African American women.[15]

Maternal and Infant Mortality

In 1913, the rate of women dying in the United States from all diseases was 15.2 per 100,000 of the white population and 26.1 per 100,000 of the African American population.[16] Conditions associated with maternity and infancy ranked third in leading causes of death for African Americans in the South.[17] During the first decade of the twentieth century, infant mortality for white and African American children in the United States was significantly higher than many major countries in Europe.[18]

The increased maternal mortality was associated with death from sepsis during childbirth.[19] In 1917, the Children's Bureau reported that more deaths occurred among women ages 14-44 years from childbirth than from any other disease except tuberculosis.[20]

The alarming rate of maternal and infant mortality led to speculation by health care professionals as to the etiology of the problem. Infant mortality was higher in

southern states than in northern states. After public disclosure of the high rate of infant mortality, physicians and health officials questioned the role of the midwife during childbirth. Public health officials and the medical community began to question the midwife's role in the birth process in hopes of identifying causes for the high infant mortality rates.[21]

Concerns about the high mortality rate united women's groups, public health officials, politicians, physicians, and social workers in efforts to learn more about the causes of infant and maternal deaths as well as to develop strategies to decrease the high rate of mortality.[22] Due to increased concern about the high infant mortality rate, a group of social workers, pediatricians and public health officials formed the American Association for the Study and Prevention of Infant Mortality in 1910 to identify causes of infant and maternal mortality and to recommend strategies to decrease infant mortality.[23]

Using government initiatives, southern states with a high number of active midwives sought to identify measures to decrease the mortality rates. South Carolina was not at the forefront of this movement. However, faced with having the highest mortality rates in the nation, the state legislature, public health officials and physicians initiated actions to provide a safe environment for both mother and baby.

The South Carolina State Board of Health, in an attempt to become aware of national initiatives to decrease mortality, sent a delegate, Dr. E. A. Hines, to the October 1917 meeting of the Association for the Study and Prevention of Infant Mortality.[24] Dr. Hines reported to his colleagues at an Executive Committee meeting of the South Carolina Board of Health about initiatives in other states to improve the health of pregnant women and children. He remarked on the effectiveness of having a coordinating

agency such as a Bureau of Child Hygiene to implement strategies for decreasing mortality.[25]

High-ranking government officials recognized the need for a Department of Child Hygiene in South Carolina, which would implement and monitor strategies to improve care to women and children. Dr. Grace Meigs, Director of the Division of Hygiene of the United States Children's Bureau, heartily approved establishing a Bureau of Child Hygiene in South Carolina.[26]

This need to improve care continued to increase as the high rate of maternal and infant mortality did not abate but increased. From January 1 to September 30 1918, there were 297 maternal deaths out of 32, 459 births in South Carolina.[27] In the annual report to the state legislature, the director of public health noted that a large number of women died during parturition and pregnancy because of dirty, ignorant midwives who were incapable of providing care and, no matter how ignorant a woman might be, she could call herself a midwife.[28]

Following the earlier efforts of Dr. Hines and Dr. Meigs, members of the Board of Health requested the South Carolina legislature to provide appropriations for a Bureau of Child Hygiene to focus on programs to aid in decreasing the high mortality rate in the state.[29] The Bureau, when established, would exist to promote better health conditions among children. Activities of the Bureau included: enforcing birth registration, instituting infant and prenatal centers, instructing and supervising midwives, improving home and school sanitation, and establishing clinics for children.[30] The South Carolina General Assembly appropriated ten thousand dollars to establish a Bureau of Child

Hygiene in 1919.[31] One of the major areas cited for supervision by the newly established Bureau was the training and supervision of midwives.

Physician Opposition to Lay Midwifery

The early decades of the 20th century marked the era of the Progressive Movement in the United States. Political parties such as: Socialist, Suffragette, Labor, Municipal Reform and Woman's Temperance Union developed, each with separate goals and agendas.[32] The respective goals included bringing about an end to capitalism, obtaining the right to vote for women, improving work conditions and wages in the United States, implementing social welfare programs, and ending alcoholic beverage use.[33]

Women became more active in health care issues and women's rights. Some of these prominent political activists and advocates for improvements in health care for women and children were Jane Addams, a leading female reformer; Florence Kelley, Executive Secretary of the National Consumers League; Lillian Wald, organizer of public health nursing at the Henry Street Settlement in New York, and Julia Lathrop who would later be appointed Chief of the United States Children's Bureau.[34] These activists spearheaded efforts to improve the quality of life for women and children and to decrease the high rates of maternal and infant mortality.[35]

As health care practices were evaluated and scrutinized in efforts to improve the quality of life for women and children, physicians focused on the midwife and called for abolishing midwifery as a means of decreasing mortality rates. The American Association for the Study and Prevention of Infant Mortality (AASPIM) became a widely

used forum for midwifery opponents.[36] The AASPIM sought to inform the public about the dangers of childbirth and the need for improved obstetrical education.[37]

During the early part of the twentieth century, the poor quality of hospitals caused many women to view them as unsafe places for childbirth.[38] Because midwives delivered women who otherwise would go to charity hospitals, physicians had diminished numbers of obstetrical cases. Thus, physicians stressed that poor women in need of obstetrical care should be in charity hospitals where professional care could be provided. Higher numbers of patients in charity hospitals would increase training opportunities for physicians.[39]

In order for obstetrics to achieve recognition and respect as a profession, many physicians stressed the importance of improving medical training. A paper by two Boston physicians, Drs. Arthur Emmons and James Huntington, presented at the American Association for the Study and Prevention of Infant Mortality in 1911, emphasized the need to provide adequate training for physicians rather than midwives:

> Until we have solved the problem of how not to produce incompetent physicians, let us not complicate the problem by attempting to properly train a new class of practitioners. The opportunities for clinical instruction in our large cities are all too few to properly train our nurses and our physicians. How can we, for an instant, consider the training of the midwife as well?[40]

Elimination of the midwife, according to opponents, would prevent unsafe practices from occurring during a delivery. The elimination of the midwife would more importantly elevate the field of obstetrics by providing opportunities for trained physicians to deliver babies.[41]

It was argued that if physicians developed expertise in obstetrics and there were fewer midwives, more women would go to the hospital. Furthermore, hospitals could

provide free care to poor women; and, physicians and students could increase their knowledge of obstetrical care. Thus, it was believed, the benefits would be two-fold.[42]

It was believed that the use of charity hospitals as a training site for physicians would help to improve obstetrical outcomes and provide a cadre of competent experienced obstetricians capable of handling all types of obstetrical cases. This would aid in increasing the number of patients for physicians while allowing physicians in training to develop clinical competence.[43] Many physicians stressed that once women viewed pregnancy as a high-risk situation requiring care by a trained physician, midwifery could be eliminated.[44]

As the need to emphasize the risks associated with pregnancy increased, efforts to encourage women to use charity hospitals focused more intensely on the need to abolish midwifery. Without regulated and sanctioned medical training, midwives were described as lacking the skills and knowledge necessary to deliver babies.[45] As argued by physicians, midwives ignorance would lead to unsafe and superstitious practices resulting in maternal and infant deaths.[46] Physicians opposed to midwifery continued to depict the lay midwife as illiterate, untrained and a danger to the women she cared for during their childbirth.[47] Such dangers as argued by physicians, resulted in maternal suffering and unnecessary infant deaths and neonatal blindness.[48] Seeking greater sanction and empowerment of their cause against midwifery, physicians expanded their battle against midwifery beyond the local and state level. As evidenced in a paper presented at the AASPIM by Dr. E. R. Hardin, a physician from North Carolina, officials at the national level were warned it would demonstrate poor judgment for the United States to attempt to

make competent obstetrical attendants of the large number of ignorant midwives now practicing in the nation.[49]

Debates about the midwife problem focused on three primary perspectives. Some physicians argued for the elimination of the midwife while others suggested raising the midwife to an increased level of competency through training. There were also physicians who believed that mandated state education and supervision of midwifery practice would alleviate the problems thought to be associated with midwifery.[50] When considering the reality of the limited access available to women in some areas and regions of the U.S., the only option deemed appropriate was regulation of midwifery in the form of educational restriction followed by registration and supervision. In the rural South especially, registration and supervision became the most feasible alternative for midwives. Through state mandated training programs midwives received instruction in cleanliness and hygiene to guide their care giving.[51]

While consensus appeared to be reached regarding the need for regulation of midwifery, the goal of many physicians remained one of gradual elimination of midwifery practice. However, in spite of this long-range goal, physicians recognized that in many rural areas midwives were the only persons available to provide assistance during childbirth.[52] A paper presented at the 1915 annual meeting of the AASPIM by Dr. J. Clifton Edgar (and later reprinted in the March issue of the *American Journal of Obstetrics and the Diseases of Women and Children*) noted that the midwife was an evil that for the current time could not be eliminated.[53] Since this "evil" could not be eliminated, it would be imperative for the midwife to be trained to work in a hygienic and clean manner. This prevailing opinion is evidenced in the following quote:

> Since the evil for the moment can not be eradicated, the danger to the public can be minimized by some provision for the proper regulation, supervision and control of midwives by the state and for her training, to do her work in a clean and intelligent manner .[54]

Essentially, many physicians hoped midwifery could be eliminated by increasing educational requirements associated with the provision of midwifery care.[55] However, the reality remained that the elimination of midwifery in certain areas and regions of the U.S. would lead to increased maternal and infant mortality rates. To eliminate the midwife in the rural South would deprive southern African Americans of a birth attendant. African American midwives were delivering the majority of black babies in the south past the 1940s.[56] African American women residing in rural areas had limited, if any, access to care during pregnancy and childbirth.[57] The combination of poverty, segregation, and rural residency made the midwife a logical choice for rural African American women.

Physicians felt that control of midwifery practice could happen through the enforcement of rules governing midwife practice.[58] Dr. Clifton Edgar, a prominent New York City obstetrician, advocated strict supervision, regulation and control of the midwife with the final and ultimate goal being elimination of the midwife.[59] Opponents of midwifery argued that if midwifery were not immediately abolished then it was necessary that midwives uphold the law and call a physician in cases of complications; and, the midwife should not perform vaginal examinations.[60]

Physicians stressed that a doctor should supervise midwives. Additionally, doctors were encouraged to make sure that midwives had a wholesome fear of the law and the state physician.[61] As Dr. Hardin noted in 1925, " bring midwives under

supervision of competent officials so their work may be subject to some kind of measure of competency and supervision".[62]

Mortality Rates of Midwives and of Physicians

Opponents of midwifery voiced their persistent concerns about lack of cleanliness in midwives practices and the absence of knowledge necessary for rendering medical care to women.[63] What frequently did not appear in debates about midwifery was physicians' contribution to the high maternal and infant mortality rates, including inadequate medical attention and the fact some physicians were poorly trained.

Some early 20th century studies revealed lower maternal mortality rates in areas having a high percentage of midwife deliveries.[64] This was in direct contrast to an increase in maternal mortality associated with physician-attended births. Dr. Whitridge Williams, a Johns-Hopkins University Professor of Obstetrics, was commissioned by the AASPIM in 1911 to conduct a survey of medical school faculty about obstetrical competencies and the safety of midwifery practices.[65] Some physicians openly admitted that a problem existed with physician deliveries.[66] Results of the survey indicated that more than one half of the sample surveyed felt the death rate from puerperal infection occurred at a higher rate in physician-attended deliveries than those attended by midwives.[67] This information did not abate calls for an end to midwifery. Rather, the calls intensified among midwifery opponents to increase the number of pregnancy cases for obstetricians as a means of attaining expertise and competency.[68]

Physician practices contributed significantly to maternal and infant mortality because of the lack of obstetrical training and the use of operative instruments. The midwife generally worked from a non-interventionist approach and, rather than trying to

hasten the labor process, or use operative obstetrics, the midwife relied on the natural forces of labor. Midwifery opponents maintained staunch opposition to midwives. However, supporters of midwifery presented compelling reasons to continue allowing midwives to provide care.

Midwifery Proponents

Although physicians were the most vocal opponents of midwifery, some doctors did speak out in favor of midwives. Proponents of midwifery focused on the need for proper training of midwives so safe care could be assured. In 1912, Dr. Abram Jacobi defended midwifery in his opening address as President of the American Medical Association.[69] A nationally recognized New York City pediatrician, Dr. Jacobi acknowledged that midwives could perform an important role in decreasing infant mortality. He stressed that prenatal care and breast-feeding were important factors in decreasing mortality, and that nurses and midwives could provide these services. Dr. Jacobi advocated training for midwives and recommended establishing two hundred midwifery schools in the United States.[70]

There was a consensus among government agencies and physicians that strategies had to be developed and implemented to address the problem of maternal and infant mortality in the United States. At the national level, actions of the Children's Bureau stressed programs and initiatives aimed to decrease mortality for all women and children.[71] Dr. Grace Meigs, Chief of the Bureau of Hygiene at the Children's Bureau, emphasized the need to prevent diseases and complications associated with childbirth. In 1917, studies conducted by the Children's Bureau revealed a connection between maternal and infant welfare, which led Dr. Meigs to report that infant mortality could not

be prevented without maternal protection.[72] Dr. Meigs also reported that conditions leading to high maternal and infant mortality rates could be prevented through proper hygiene, supervision during pregnancy and skilled care at delivery.[73]

Dr. Meigs advocated the need for all women to receive competent care during childbirth. As an advocate for women, Dr. Meigs stated it was important for them to be regarded as both useful to the state and needed since the death of women represented a serious loss to the country.[74] She was concerned about disparities between white and African American women concerning deaths from childbirth fever. In 1913, the mortality rate from all diseases caused by pregnancy and confinement was 15.2 per 100,000 white population and 26.1 per 100,000 colored population.[75]

In the midst of opposition to midwifery throughout most of the rest of the United States, the position of many southern physicians and health care professionals continued to offer a voice of advocacy for maintaining the role and care offered by the midwife. Few physicians practicing outside of the southern region who supported the elimination of midwifery could be expected to move and establish their practices in the South. There was little money, if any, to be made by serving poor, rural women patients attended by midwives. Southern public health departments began establishing training and regulatory programs for midwives beginning in 1921.[76] At the same time many southern health officials were hopeful that through regulations the midwife could be abolished.[77]

Some southern physicians and government officials held a more tolerant attitude toward midwives. Many southern physicians continued to view the midwife as unavoidable and called for supervision and training by the state to prevent the death of women during childbirth.[78] Some physicians believed that placing midwives under state

control and enforcing educational requirements would eliminate incompetent midwives and improve the quality of midwifery care.[79]

Furthermore, public health officials understood the importance of midwives to poor and rural African American women, and stressed that midwives would continue to be needed by these woman. Proper training and supervision for midwives could aid in decreasing maternal and infant mortality. Other factors that made southern public health officials and physicians more amenable to African American midwives were the small number of African American physicians and a lack of access to white hospitals.[80]

Medicalization of Childbirth

The need to legitimize obstetrics as a worthy and dignified profession became the driving force for physicians advocating an end to midwifery. Physician opponents of midwifery argued that, if untrained midwives continued to perform the same tasks as physicians, obstetrics would never advance as a profession.[81]

Another reason to abolish midwifery besides efforts to advance obstetrics as a profession was economics. Physicians viewed the midwife also from an economic perspective. A midwife charged significantly less for a delivery than a physician did. There were thousands of young physicians according to Dr. Joseph DeLee who would take cases that midwives were managing, were it not considered undignified and, both the work and fee too small for obstetrical services.[82]

Opponents of midwifery such as Dr. Joseph DeLee, a prominent obstetrician, founder of the Chicago Lying-in Hospital, and the author of a nursing text *Obstetrics for Nurses* that became a standard textbook, felt that midwifery should be abolished. Midwives according to De Lees' description were "a relic of barbarism because in

civilized countries a midwife is wrong".[83] In writing about the midwife, Dr. DeLee noted that the midwife is innocent of the trouble she causes; and, it is not her fault she was allowed to practice such a delicate profession.[84] The physician was at fault because if he recognized the dignity of the profession, midwives would not exist. Dr. DeLee adamantly opposed any attempts to continue midwifery. The following statement summarizes his position:

> I feel certain that if every midwife in America were to vanish today, before the week ends every woman in the United States would be cared for and cared for much better than she is today.[85]

In the early 1900s, women increasingly sought hospital births in part because of beliefs that pregnancy was a pathological condition requiring medical supervision.[86] In the 1920s, physicians began to promote a new paradigm of pregnancy and childbirth. Heretofore, the public considered pregnancy a normal occurrence. Many physicians began to express views that the public should view pregnancy as a potentially dangerous condition requiring care from a trained professional.[87] Physicians emphasized that childbirth in the home posed a serious health risk to a woman and her unborn child.[88] The medicalization of childbirth occurred with a shift from home delivery to physician-assisted deliveries in hospitals. Physicians argued that obstetrical complications a woman might experience during childbirth necessitated hospitalization to assure the safety of both the pregnant woman and her newborn baby.[89] Physicians emphasized to the public that a physician-assisted delivery in the hospital decreased chances of maternal and infant mortality.

Medical advances ushered in new techniques available to women to facilitate a medically controlled childbirth.[90] Increased public awareness about techniques that

resulted in a less painful childbirth also contributed to an increase in hospital deliveries. For example, the availability of medicines to ease the pain of childbirth served as an additional inducement for delivery to occur in a hospital, rather than at home.[91] Twilight sleep or anesthesia during childbirth became a viable option for many women and gained popularity in the United States beginning around 1914.[92] The combination of morphine and scopolamine provided a painless childbirth as women were medicated during labor, experienced a light sleep and awoke after the delivery with no memory of any pain. Women's magazines featured advertisements for twilight sleep, and prominent socialites, such as Mrs. John Astor of New York, endorsed the use of twilight sleep for a pain free childbirth.[93]

Beginning in the 1920s the use of forceps made it possible for the newborn to be delivered without a woman being in prolonged labor.[94] These medical advances were not available to midwives, but could be performed at a hospital where physicians practiced. These factors aided physicians' arguments that midwives should not be delivering babies. Upper middle-class and white urban American women replaced midwives with physicians as their caregivers. Midwives continued to deliver babies for rural, working class, immigrant and African American women well into the twentieth century.[95]

Government Initiatives to Improve Maternal and Infant Health

The Children's Bureau

Widespread support for initiatives to decrease maternal and infant mortality rates came from women's organizations, politicians and medical organizations.[96] Over 200 delegates representing child welfare agencies attended the first White House Conference on Care of Dependent Children in January 1909.[97] This conference was intended to

stimulate public interest in health care for children. Conference attendees recommended that an agency, the Children's Bureau, be formed to focus on the needs of children. This agency would study and identify conditions that affected maternal and infant mortality.[98]

President William Taft, on April 19, 1912, signed into law Statute 252, establishing the Children's Bureau in the Department of Labor.[99] This legislation was enacted by the Second Session of the 62nd Congress. The Children's Bureau had the broad authority to "investigate and report on all matters pertaining to the welfare of children and child life among all classes of people.[100] Areas recommended for surveillance were: infant mortality, birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children in the states and territories.[101]

Staff from the Children's Bureau collected data on conditions pertaining to child welfare and child life among all classes of people. Studies done through auspices of the Bureau sought to obtain data about social and economic influences that contributed to maternal and infant death.[102] Findings from these studies were shared with the states to develop and implement measures to improve care of pregnant women and children. Study findings provided a basis for proposing grants-in-aid to the states so that programs could be implemented. Reports and findings issued by the Bureau made clear the need for states to improve existing services designed to promote the health of women and children.[103] Bureaus of Child Hygiene were recommended for each state so that programs for women and children could be managed properly. By 1929, 46 of 48 states had a special bureau to deal with issues related to infant and child health. [104]

Two initiatives started by the Children's Bureau were the establishment of a national birth registry and implementation of measures to decrease the spread of

gonorrhea to newborns.[105] States using funds disbursed through the Children's Bureau developed training programs to teach midwives how to instill silver nitrate in the eyes of a newborn to prevent gonorrheal infection. [106] One of the roles maintained by the Children's Bureau was assistance to states to develop maternal and infant programs, as well as conduct studies and issue reports about the status of maternal and infant health to increase the nation's awareness of the need for continued programs to decrease mortality rates. Nine years after the Children's Bureau began to collect and report data, pressure mounted on Congress to take necessary actions to address high maternal and infant mortality.[107] Pressure came from members of both political parties and women's groups for Congress to provide additional funding so more comprehensive programs could be developed.[108]

The Sheppard-Towner Legislative Act for the Promotion of the Welfare of Maternity and Infancy

Congressional action to address the problem of infant and maternal mortality began with a proposed bill to provide social welfare programs to the states and provide maternal and infant health care through federal grants-in-aid to the states.[109] Legislation introduced in 1919 in the U.S. Senate by Morris Sheppard and in the House of Representatives by Horace Towner became law on November 23, 1921.[110] This legislation, enacted by the 67th Congress and commonly referred to as the Sheppard-Towner Act, provided matching funds to states to aid in developing programs to reduce maternal and infant mortality and to promote the health of mothers and their infants.[111]

States began to receive this federal money in May 1922 with funding continuing until June 1929.[112] The Sheppard-Towner Act provided the first public health grants-in-

aid program in the United States. Federal matching funds were provided to states for midwife education, prenatal and child health conferences, visiting nurses services, and instruction on hygiene and nutrition for families.[113] During the seven years of funding, Congress appropriated under $7,000,000 to grants-in-aid programs to improve maternal and infant health outcomes.[114]

Many states used these grants to provide midwifery training for rural African American midwives. In addition to training programs, states could hire public health nurses to supervise midwives and prepare training manuals for their education.[115] The Bureau of Child Hygiene and Public Health Nursing in South Carolina received an appropriation of $10,000 funding in 1919 for supervision and training of midwives.[116] This appropriation enabled South Carolina to hire a nurse consultant to provide midwifery training and supervision.

After discontinuance of the Sheppard-Towner Legislative Act in 1929, the costs of supervision, training and licensing of midwives became a state responsibility.[117] States were required to use state funds to finance programs. Funding from federal sources was not available again until 1934 through disbursement from the Office of Federal Emergency Relief Administration (FERA).[118] This office was created in March 1933 through an act of Congress to provide monies to states for health relief.[119] This aid was used in the South to identify the needy and provide funds for programs aimed at care for the needy. Funds became available to state boards of health for maternal and child health programs.[120]

These funds came with federal guidelines. Heretofore, funding from federal agencies allowed the states to set guidelines for program initiatives. However, beginning

in 1934, states received funding to implement national policy under the direction of the federal government. [121] The federal government's role had been advisory; whereas, it now became the policy maker.

Public Health Supervision of Midwives in South Carolina

With the support of federal funding, the states could provide programs aimed toward improving maternal and infant health. Board of Health officials considered midwives a necessity for such programs because 20 percent of white mothers and 80 percent of African American mothers depended on a midwife to deliver their care.[122] Public health officials advocated making the 'best of a bad bargain' by enforcing rules and regulations for midwives.[123]

In other words, public health officials in South Carolina considered midwives a problem and a necessity. Midwives were considered a problem because they were untrained, lacked supervision and used unsafe practices. The director of the Bureau of Vital Statistics attributed the high rate of maternal mortality to midwives:

> We allow dirty, ignorant women to proclaim themselves capable of taking care of mothers at this time when they should have the most skillful care and attention. There is no midwife law in South Carolina. No one, no matter how ignorant she may be, is debarred from calling herself a midwife. They are neither licensed, nor inspected, nor do they know anything in regard to what is necessary to preserve life under these circumstances.[124]

In 1919, the Executive Committee of the State Board of Health established rules and regulations to govern midwives in South Carolina.[125] After midwifery registration was implemented in 1919, the level of control of midwives in South Carolina continued to evolve. In each county, midwives were subject to supervision and control by the county health officer and were required to report to either the county public health nurse or county health officer whenever necessary.

Specific criteria had to be met to obtain a midwifery certificate in South Carolina. The midwives had to be able to read and write, have good vision, average intelligence, and have generally good health.[126] A midwife had to provide proof she did not have a communicable disease, as evidenced by a negative Syphilis test or other proof of being non-infectious.[127]

Requirements to maintain certification as a midwife in South Carolina included attending classes, maintaining requirements for certification to practice (i.e., proof of literacy, good vision, average intelligence and good health), completing birth certificates and making sure that pregnant women under her care had a physician evaluation before engaging the midwife.[128] One major restriction was that midwives were prohibited from performing vaginal examinations. If a midwife was found to have performed a vaginal examination, she could lose her permit.[129]

In the early 1920s, the South Carolina Board of Health with additional funds from the Sheppard-Towner legislation began to develop and implement training programs for midwives.[130] Public health initiatives sought to educate the midwife about basic hygiene and sanitation that should be performed during labor and delivery. Public health officials recommended supervision of midwives by a public health nurse and a local physician to ensure safe practices were being implemented during childbirth.[131] Linkage of the midwife with a physician provided a means for her to obtain medical assistance should complications occur. The South Carolina Code of Laws specified a midwife had to report to the local public health nurse or the county medical officer as required. The purpose of this linkage was to provide stricter observance of midwives in order to decrease the mortality and morbidity rate of mothers and infants.

Federal funds provided to the South Carolina Bureau of Child Hygiene made it possible to hire a nurse, Laura Blackburn, for statewide supervision and instruction of midwives. Ellen Woods Carter, an African American field nurse, was hired to "work among her people" in the state.[132] However, her salary was paid through the state operated Black Church Mission Board.[133] Nurse Carter's responsibilities included registration and instruction of midwives and public health activities among African Americans.[134] In 1923, 403 midwives received certificates in classes taught by Nurse Carter.[135]

Beginning in 1926, the organization and supervision of midwives became more widespread with 63 groups of midwives enrolled in classes.[136] Officials of the South Carolina Board of Health sought to eliminate midwives considered illiterate and unable to comply with requirements. Midwives, whom authorities deemed teachable, would be licensed, while others would be eliminated.[137] The nurse in charge of the Bureau of Child Hygiene and Public Health Nursing noted that in the year 1926:

> An effort is being made to weed out very old midwives as well as the most ignorant and superstitious. The field nurse reports that, as the rules in regards to the work and attendance at review classes are more strictly enforced, there is a growing tendency for the old grannies to resign.[138]

These control measures over lay midwives also extended to Negro women seeking information about employing midwives. When a midwifery class was offered by the Bureau of Child Hygiene in Lexington County, South Carolina many women came to the class as applicants, while some women came to learn what kind of care they had a right to expect from a lay midwife.[139] Apparently, the county medical society considered this an inappropriate action because after three weeks, at the request of the county medical society, the instructor was withdrawn and classes canceled.[140] The only

explanation provided to the state midwife supervisor was that the medical society did not approve of giving certificates to these women.[141] This example illustrates how powerless African American women were to effect change and how their efforts to become a midwife were limited.

In South Carolina from 1926 to 1927 the infant and maternal mortality rate declined from 135 per 100,000 to 90 per 100,000 with a decline in the maternal mortality from 10.1 per 100,000 to 8.3 per 100,000.[142] Credit for the decline was attributed to measures instituted through the Department of Child Hygiene and the work of nurses who stressed cleanliness and laws midwives were required to observe in caring for women.[143] It is interesting to note that no mention is made of the role of midwives in helping to decrease the mortality statistics.

With the ending of Sheppard-Towner funding at the start of the Great Depression, states had decreased budgets for health care programs. The Children's Bureau collected data during the first years of the Depression and proposed plans for children's health and welfare programs.[144] The plans which would later become the basis for the child health and welfare component of the Social Security Act was comprised of three major program proposals: 1) aid to dependent children; 2) maternal and child health services; and 3) child welfare services for children needing special care.[145] Initially the program was primarily focused on prenatal and postnatal clinics and the training of professional personnel.[146] Under the maternal and child health program, monies were allocated for midwifery training.[147]

The Board of Health continued with strategies to improve maternal and infant

health status in South Carolina. Having made progress in improving care to pregnant women and infants, states were able to secure federal funds for maternal and child health programs in the 1930s resulting from passage of the Social Security Act of 1935.[148] Money appropriated through the Social Security Act provided for a comprehensive health system. Millions of dollars were awarded to states for problems such as maternal and infant care, environmental sanitation, malarial control and industrial hygiene.[149]

In a 1937 Children's Bureau report on the Health-Education Program of the Children's Bureau with Particular Reference to Negroes, it was noted that the 48 states, Alaska, Hawaii and the District of Columbia were cooperating through state health departments in the maternal and child health program.[150] At the time of the report it was estimated that more than 200,000 mothers were delivered annually by midwives.[151] The report attributed midwives to be attendants at more than half of the deliveries of African American babies in the U.S. and also attendants for the majority of deliveries in rural areas of the South.[152]

Many southern communities constructed health centers so that care could be provided to pregnant women and children. The number of clinics throughout the South increased, along with a subsequent increase in the number of women seeking prenatal care at the clinics. In 1931, there was a decrease in the maternal and infant death rates for African American women in South Carolina while the rates for white women did not decline.[153] The Board of Health in its annual report acknowledged how valuable this finding was to the state and noted that because a midwife delivers most of the Negro women the midwife training was helpful.[154]

Attendance at clinics to receive prenatal care appears to have been more predominant among African American women than among white women. In 1940, 30 percent of African American pregnant women in South Carolina sought prenatal care at clinics.[155] Fewer white women attended prenatal clinics in comparison. At the beginning of the 1940s the number of physicians and health care facilities were in short supply. The need for physicians to serve in the military as health care providers during World War II further reduced the availability of physicians. In 1940, there were 133 physicians for every 100,000 Americans or about one doctor for every 752 people.[156] In the south the number of physicians was significantly decreased. South Carolina in 1944 had over 3,000 people per active physician.[157] Health care providers for African Americans were even more limited. In 1942, South Carolina had 67 physicians and 250 graduate nurses working in the state.[158] By 1944, with so many physicians in active military service, civilian doctors saw on average 1,700 people per year.[159]

World War II brought about an expanded military service with large numbers of enlistees. Many of the service wives relocated to areas where their spouses were stationed. With the increase in populations in many areas, there was a subsequent increase in the demand for hospital care. Because of a sudden concentration of military dependents at military facilities in South Carolina, thousands of young wives, expectant mothers and infants were unable to find care or afford needed medical assistance.[160]

In 1943, the Children's Bureau sought to assist states to develop the best response to an increased need for maternal services through the need for improvements in delivery of maternal health care. The lack of hospitals to treat patients fueled the need for more hospitals to be constructed. The national response to the medical crisis in the vicinity of

military bases was the establishment of the 1943 Emergency Maternal and Infant Care program (EMIC). [161] The EMIC program continued until 1947 and provided funds for free hospitalization, maternal and infant care for dependents of service men in the lower pay grades and also the upgrading of obstetrical and gynecological services in hospitals.[162] These funds provided opportunities for states to upgrade hospitals and health care facilities.

The emphasis on quality care raised standards for hospital care and on August 1946, a bill sponsored by Senator Lister Hill and Congressman Harold Burton created the Hill-Burton Act. The Hill-Burton Act provided a five year $75 million program of grants in aids for hospital construction passed the Congress.[163] Through allocation of Hill-Burton Act funds, hospitals were constructed in rural areas so that people living in rural communities could receive care at a hospital.[164] As the decade of the 1940s neared an end, more health clinics were constructed to increase the availability of maternal services and other types of health screening to women.

The beginning of the decade of the 1950s included an increase in the number of patients coming to prenatal clinics, particularly African American pregnant women. It is notable that the services of midwives continued to be needed. In 1949, 60% of African American women sought a midwife as the birth attendant, compared to 2.5% of the white population seeking a midwife.[165] By 1950, all practicing midwives were trained in scientific principles and South Carolinas' midwifery program began to receive national attention. A photo essay of an African American nurse midwife, Maude Callen, was featured in a December 3, 1951 issue of Life Magazine.[166] Nurse Callen was one of the few nurse midwives practicing in the state. The article and accompanying photos

illustrate how this nurse midwife was able to help disadvantaged patients who had limited access to care.

By 1952, each county in the state had a local health department.[167] In 1952 Midwives delivered 24% of the total deliveries in the state.[168] Midwives received training at Midwifery Institutes. At the Institutes midwives learned about safe care for the childbearing woman and care for the newborn. Midwifery Institutes continued to offer classes annually so that midwives could receive instruction about caring for the pregnant women and so that midwives could remain certified to practice. Emphasis was placed on teaching midwives about nutritional needs for mother, the importance of breast-feeding because breast milk was the best source of nutrition for the infant, the importance birth registration, tuberculosis and venereal disease screening. [169]

By mid-1950s, the aim of local health departments was to have as many women under medical care as early as possible in pregnancy to minimize obstetrical risk and complications. During 1956-1957, there were 1846 prenatal clinic sessions with 22,133 total women attending.[170] African American women comprised 69 percent of the patients seeking prenatal care.[171] For the same time period 65.25 percent of women seeking prenatal care had engaged one of the 1,029 midwives certified for that year.[172]

In 1960, the number of midwife deliveries of babies born in the state had declined 4% from those delivered in 1955.[173] During the next decade, the number of midwives would decline as women were able to purchase insurance to cover the cost of hospitalization and as hospitals were built in the smaller towns and cities of the state. The trend toward hospital deliveries increased and the number of midwives continued to decline. The decline in midwifery delivery statewide paralleled the decline in midwifery

deliveries in Georgetown county (See Table 1 and Table 2). By 1969, deliveries accounted for by midwives were 2,334 for 261 midwives certified in 31 counties of the state.[174] During the early to mid seventies, deliveries by midwives declined from 2,194 in 1970 to 890 by 1974.[175]

Table 1

Live Births Delivered By Midwives in South Carolina 1950-1970		
Year	**Total Births**	**Midwife Deliveries**
1950	57,082	15,677
1955	63,530	11,662
1960	59,702	7,646
1965	52,853	4,709
1970	52,283	2,194

Source: Division of Biostatistics. Office of Public Health Statistics and Information Services, SC Department of Health and Environmental Control

Table 2:

Live Births Delivered By Midwives in Georgetown County South Carolina 1950-1970		
Year	**Total Births**	**Midwife Deliveries**
1950	989	487
1955	1067	446
1960	953	323
1965	784	228
1970	696	111

Source: Division of Biostatistics. Office of Public Health Statistics and Information Services, SC Department of Health and Environmental Control

Midwifery Institutes

The aim of teaching midwives was to aid in decreasing the high rates of African American maternal and infant mortality. Midwives were instructed about fundamental principles to be observed by them in the practice of their work.[176] These "new" midwives were considered a different type of midwife because they were able to learn from professionals how to deliver babies.

To ensure adherence to rules and regulations all midwives were required to attend a Board of Health sponsored Midwifery Training Institute every 4 years.[177] Only midwives attending the Midwifery Institute could receive a permit to practice.[178] The

Midwifery Institute provided detailed instruction for new midwives and a review of midwifery care for those already certified as midwives. After completing training at the Midwifery Institute, midwives would be supervised in their local county by a public health nurse and the county health officer.

The Midwifery Institutes that began in the 1920s continued throughout the 1930s with attempts to register midwives from all counties. Institute classes consisted of midwifery, home hygiene, care of the sick, infectious diseases, and first aid (Appendix 3). Public health nurses taught prenatal care, delivery care with special lectures on birth registration, venereal diseases, crippled children, and care of premature infants.[179] Demonstrations consisted of bed making, bed baths, enemas, douches, and preparations for delivery, delivery, postpartum care, and taking temperatures.[180]

The idea of being a new kind of midwife was reinforced in lessons and in ceremonies at the Midwifery Institute. An example is a performance by a group of midwives at a Midwifery Institute graduation ceremony in 1927. Student midwives performed a play written by the State Midwife Supervisor entitled, "The Old Order Passeth".[181] This play emphasized the differences between the old and the new midwife. In order to differentiate the new midwife from her predecessor the Board of Health implemented uniform dress codes for midwives. A regulation cap and apron was adopted in 1931.[182] The uniforms were blue with white collars and short sleeves and a full white apron and cap.[183] The uniform was to be worn when the women left on a call to deliver a baby. Upon arriving at the home of a laboring woman, the midwife would place her hair under the cap and put the apron on over her midwife uniform.[184] The uniform worn by the midwife would indicate to the public that the midwife was part of an organized group.

This type of organization of midwives was similar to other transitions that were occurring in other fields at the same time as midwifery. Beginning in the late 1920s technological advances fueled the growth of many industries. Accompanied with economic growth were efforts to organize workers and consolidate the activities of workers.[185] Many types of workers such as midwives were identified by the type of uniforms or garments they wore.

Training for midwives continued into the 1940s and 1950s with an emphasis on eliminating "grannies" the name commonly used to describe the older order of midwife. The goal was to prepare a midwife who was adequately trained. To ensure accuracy of birth registration forms the South Carolina Department of Adult Education provided a teacher at the Institute to assist the women in learning how to complete birth certificates correctly.[186] While at the Institute midwives demonstrated skills such as hand washing, preparing the room for delivery, providing sterile care during delivery, providing hygiene for the mother and newborn, care of the cord, weighing the baby, after care of the mother and delivery bag care.[187] Evaluation of students' acquisition of knowledge focused on student midwives demonstrating how to provide care for a laboring woman and the newborn after delivery.[188]

As a means to establish a new order, emphasis continued on improving the delivery of maternal services provided by lay midwives in the state. Midwifery Institutes became more detailed in the 1950s as the methods of instruction for the midwives included lectures, demonstrations, motion pictures and practice work.[189] A 78-page *Midwifery Manual* was introduced with detailed sections about midwifery care and the physiological changes of pregnancy. The lessons in the manual focused on training

midwives about the physiological aspects of pregnancy, nutritional needs of the mother and infant, crippling conditions of the new born, birth registration, venereal disease and tuberculosis.[190] Public health officials noted the importance of Midwifery Institutes in helping to improve the work of the midwives and reducing the maternal death rate.[191]

County Supervision of Midwives

Midwives had to register with the local registrar and the County Health Department.[192] Locally, midwives had to attend monthly meetings supervised by county public health nurses for the purpose of training, discussion of cases, and inspection of their bag.[193] The public health nurse made supervisory visits to the communities where the midwives practiced and scheduled monthly meetings. The public health nurse conducted classes and provided supplies as needed. Lessons on hygiene and basic care of the mother and newborn were also taught at monthly meetings. At each meeting, lectures and demonstrations provided information about procedures, such as cutting and caring for the infant's umbilical cord, instilling silver nitrate in the eyes, stimulating the infant to breath, bathing the baby, washing of hands and making beds. Midwives would practice skills learned after a demonstration by the public health nurse.[194]

Inspection of the midwife's bag received particular attention at each meeting. The bag check verified that contents were in accordance with state requirements. Inspection of the bag also helped the public health nurse assess cleanliness and determine if the bag contained the proper equipment needed for labor and delivery. These monthly meetings were an important requirement for all midwives.

Racism and Sentiments Toward Midwives

Registration and supervision of midwives was not intended to provide for the economic or professional advancement of lay midwives since high maternal and infant mortality was attributed to midwives' unsafe practices. Thus, midwives were regulated and supervised to control their activities, as a means of decreasing maternal and infant mortality. The initial intent of these regulations was to weed out old "grannies" and establish a new kind of midwife. This new kind of midwife was trained in science about changes that occur during pregnancy and how to care for the pregnant woman and the newborn. The goal of training a midwife how to provide safe care based on medical principle was intended to aid in decreasing the high rate of infant and maternal mortality in the state.

White supremacy dominated both the political and economic landscape of South Carolina well into the 1950s. Governor Strom Thurmond, in his campaign for Senator in 1950, acknowledged how important it was to preserve the "southern" way of life.[195] Dr. James Haynes, Director of the South Carolina Board of Health, was an acknowledged white supremacist who felt the poor health of African Americans, as revealed in national mortality data, was more of an embarrassment than a challenge.[196] Historian Edward Beardsley writes that on several occasions Dr. Haynes stated that, but for the black, South Carolina would have an enviable health record.[197] Racial bias is further evidenced in South Carolina's Board of Health Annual Reports to the legislature. These reports contain information about the activities of nurses in the Bureau of Child Hygiene and Public Health. The title for the white nurse identified in the report was formal (i.e., Miss

Taylor, Miss Blackburn).; whereas, race is mentioned for the "colored" field nurse and her title is listed as "nurse".[198]

This type of racial climate was present from colonial times. This pervasive sentiment and attitude was ingrained in many Southern whites as the norm and accepted by the southern African Americans as a custom of the time. Midwifery practice by African American women under these circumstances demonstrated their commitment to provide quality care despite the prevailing racial sentiments in South Carolina. This is the environment in which African American women became midwives. Their calling came from the need to earn a living and knowing they could find work in their community.

Summary of the Findings of the Literature Review

Throughout the United States increased attention to health care was influenced by the recognition of the high mortality and maternal death rates. Government policy initiatives to improve health care gained acceptance among many states. Female reformers sought to obtain public support and government funding for programs to improve health conditions. Efforts of reformers were concentrated on persons who had limited access to hospitals due to poverty, distance from health facilities or segregated facilities. Reformers focused on the links between the health of the woman and the health of the country. Women as viewed by the reformers were vital to families. Dr. Grace Meigs of the Children's Bureau noted in 1917 that:

> Death at childbirth is a serious loss to the country. The women who die from this cause are lost at the greatest usefulness to the state and to their families, and they give their lives carrying out a function which must be regarded as the most important in the world.[199]

The Children's Bureau created through federal legislation in 1912, referred to earlier, was given responsibility to study factors related to infant and maternal mortality.[200] It was

through such studies and reports of the Children's Bureau that the proposed Maternity and Infancy Act (Sheppard-Towner) was supported and created in 1921 to develop health services for mother and children.[201]

Medical education progressed beginning in the early twentieth century. The Flexner Report in 1910 evaluated medical schools and rated them according to safety and adequacy for care giving.[202] The publishing and circulation of this report forced the closing of many medical schools and hastened reforms in the standards, organization, and curriculums of medical schools.

New Deal programs under the Roosevelt administration provided social welfare programs on a national level. The Federal Emergency Relief Act in 1933 provided a source of funding medical care to citizens.[203] The Social Security Act of 1935 designated federal funds for maternal and childcare, crippled children and the promotion of state and public health departments.[204] As previously stated, the Hill-Burton Act of 1946 provided federal funds for construction of hospitals in rural America particularly in the South where the greatest need for hospitals existed.[205]

Alternate modes of transportation such as automobiles provided a way to reach hospitals and clinics. The ability to obtain medical insurance through employment benefits increased access to health care for a large segment of the population that previously had limited, if any, access. Factors such as improvements in public education, increase in the number of hospitals and clinics, and increased employment aided an increase in access of individuals and families to health care as well as improvement of some health outcomes.

As evidenced in the review of the literature, the historical context of midwifery at the turn of the 20th century was one that was largely characterized by ongoing change directed towards increasing the knowledge of practicing midwives. A number of factors influenced the degree to which change was pursued during this time. Physicians voiced opposition to midwifery for a variety of reasons. In their views, midwifery practice was unsafe, the perceived need to create further training and clinical practice opportunities for physicians in the area of obstetrics and the desire to gain greater control over the field of obstetrics.

In spite of this opposition, the economics associated with the provision of medical services to pregnant women and newborn was not promising or financially rewarding at that time and few opportunities to gain experience in obstetrics existed outside of charity hospitals and clinical practice in impoverished and rural regions of the country. The ultimate goal of many physicians to eliminate midwifery persisted. Through the efforts of many who advocated for midwives, including physicians and public health professionals in the South, the focus of ongoing change efforts was to create safer and more regulated midwifery care practices in order to insure the safety of newborns and mothers.

As well, the medicalization of pregnancy altered social views about pregnancy and childbirth. Medicalization of pregnancy was largely initiated by physicians and suggested that maternal and newborn needs were best served in hospital settings, under the guidance of a physician, due to the dangerous nature of pregnancy itself. Consequently, a number of governmental initiatives were implemented that assisted in further strengthening health care services to pregnant women and children throughout the

U.S. However, in rural areas of the South, midwives continued to provide care for poor women.

In reviewing midwifery related literature and public records, it is evident that many of the same influences described above were operating to guide and determine changes concerning midwifery related to midwifery in South Carolina. However, in this region of the country, because of the rural nature of the area during the early to mid-1900s, there was greater support for midwifery. The support was more associated with the realities experienced by poor white and African American women who were pregnant rather than a desire to further develop and sanction the field of midwifery. Regardless, as was evidenced within the review, a number of initiatives were implemented in order to increase the safety of midwifery care. These initiatives included ongoing supervision, formalized training, certification, and ongoing training in updates and demonstration of important skills needed by the midwife.

As documented in the literature review on midwifery in South Carolina, African American midwives were subjected to the prevailing climate of racism throughout the South. While the role they assumed was perceived as a necessary evil, there was little support or value associated with the services that they provided. Most often, with lack of access to work and educational opportunities within the larger white community, African American women turned to midwifery because they needed to support their families. Women opting to become a midwife also recognized the need for midwifery services in the African American community.

Strengths and Limitations of the Literature Review

As evidenced within the review, there is a substantial amount of information available regarding the efforts to bring about change within the field of midwifery during the early to mid-1900s. Much appears to be known about the experiences and motivations of public health and medical professionals in their efforts to eliminate or sustain midwifery. As documented within the literature and addressed in the preceding summary of the findings of the literature review, many changes did occur that affected the care giving of midwives.

While records exist of the role and sentiments of medical and health professionals during this period of ongoing change in midwifery, there is little, if any information, based on the voices and experiences of those who served as midwives. While midwifery received greater sanction for a longer period of time within impoverished rural regions of the South and in African American communities, the voices of African American women who were midwives are generally absent in the literature. As the practice of midwifery is assumed to have changed significantly in all regions of the country after the 1970s, the opportunity to record and document the experiences of African American women who were midwives during the 1950-1970 time period will soon be lost, because of the advanced age of this population.

While the opportunity still exists, the knowledge base on midwifery and its role in providing health care to women and children would be strengthened by learning more about the activities or realities of life as a lay midwife and the care provided to pregnant women within the public health structure. Such information would also contribute to an understanding of how the structure of midwifery affected society. The opportunity to

document the experiences and history of midwives offers the opportunity to develop a rich knowledge base about midwifery in rural South Carolina

Summary of the Chapter

Chapter Two has provided a review of the literature on midwifery during the early to mid-1900s in the U.S. as well as a specific focus on South Carolina. The findings were documented and subsequently summarized and the strengths and limitations of the current literature were addressed.

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Chapter Three

Research Methodology

Introduction

Within Chapter Three, the research design used for the study will be discussed. Information will also be provided as to the research methods used within the study including social history, identification of primary and secondary sources of data, research variables under investigation, description of the sample, and data collection. The data analysis methods used for analyzing the data will be explained. Limitations of the study will be reviewed, followed by a discussion on ethical considerations and a description of the sample. The implications of the study to nursing will be discussed. The chapter will conclude with a summary of Chapter Three.

The research design, methodology and data analysis procedures applied within the study were selected on the basis of the purpose of the study and the research questions addressed. The purpose of the study was to provide a reliable and valid historical account of the experiences and practices of African American women who served as midwives between 1950-1970 in South Carolina. The overall goal of the study is to provide a record of the personal experiences of the rich traditions of midwifery in rural South Carolina while there are those present who lived, helped to create and can speak with authority of the experiences of African American midwives.

The research questions selected for investigation were as follows:

1) What were the personal experiences of midwives within the African American community in South Carolina during the decades of 1950-1970?

2) What factors influenced African American women in their decision to become midwives?
3) What were the training experiences of women who chose to be midwives and how did they describe their training?
4) What were the experiences of midwives in helping to deliver babies during this time period?
5) What was the nature and types of problems they experienced with some deliveries?

Research Design

For the purposes of the study, the research was conducted on the basis of qualitative research methodology utilizing a historical approach. Historical methodology is useful for the purposes of critically examining and analyzing past events. According to Glass, "Historical research is done for one of the following reasons: to discover the unknown; to answer the question, why?; to look for implications or relations to the present; and to communicate the past accomplishments of individuals as well as the profession".[1] Studying the past is valuable because such study provides useful information for the present. This is a primary assumption underlying the use of the historical method.[2] Another assumption for the use of the historical method is that data are available.[3]

In implementing a historical approach in this study, oral history and documents were used as sources of information for the research. Oral history can be defined as a process of collecting information, usually by a means of a tape-recorded interview, reminisces, accounts and interpretations of events from the recent past which are of

historical significance.[4] Oral history is recognized as having value to create a sense of continuity across generations, and is particularly true for minority and ethnic groups such as disenfranchised African Americans.[5] Gary Okihoro maintains that oral history "is not only a tool or method", but that " it is also a theory of history which maintains that the common folk and the dispossessed have a history and that this history must be written".[6] Oral history provides a voice to the valuable contributions of people who might otherwise go unrecognized.

Research Method

African American lay midwifery is the area of study for this research with particular focus on the personal descriptions of lay midwifery experiences in rural South Carolina. Consequently, the study applies the research method of social history to explore lay midwifery experiences. Social history provides the opportunity to explore how human beings in their every day life are affected by the things around them.[7]

Through the application of this method, social history provides a means of recording the activities of groups excluded from social power in the past.[8] The social history method is used in this research to seek and obtain direct source material from the persons involved. Through the application of a methodology and design that allows for the study of primary sources of data, the investigator has the capacity to access individuals in order to obtain their description of their experiences rather than having their behavior described by others. The lived experiences of the individuals, their values and behaviors, provide a representation of the worldviews of the individual and become the points of reference.[9]

While archival reports about lay midwifery in South Carolina contained descriptive data about delivery rates and numbers of midwives, such records do not provide a detailed account of the actual experiences of the midwives. Articles about midwives are generally written about the practices of midwifery, but tend to feature little midwifery comment, and generally lack full accounts of midwifery care by the actual providers.

A premise of the social history approach is that social conditions and social changes are a foundation for other historical processes because of the manner in which social history is affected by the interactions of individuals and groups.[10] The social history design allows for gathering and recording of information about the daily experiences of people who previously had no voice in historical records. Social history, as used in this research, provides a method for describing the activities or realities of life for lay midwives and the care they provided to pregnant women within the public health structure of South Carolina.

Through the use of this methodological approach, the experiences of the lay midwives can be studied with a focus on behaviors and activities of the midwives and their contribution to social changes. The importance of descriptions of midwife experiences provides a history of women who were a part of the social structure and who were also affected by the social structure of the times. The actions of the midwives, their emotions, feelings, values and behaviors provide a glimpse of their world view. This is important because, rather than the investigator having to rely on information based on second hand accounts of the experiences of others, the women who were midwives are

able to provide descriptions of their experiences and tell their own stories, within their own voices.

The types of data used in this study were information collected via interviews with lay midwives, literature on the history of African American health care, slave narratives, archival documents about lay midwifery and African American health care, and federal programs for maternal child health.

Sources of Data

Primary sources of information are considered the most reliable source of data. Primary source information is obtained from those who witnessed events and is considered original because it existed at the occurrence of the event.[11] Within the study, the African American lay midwives interviewed about their experiences served as primary sources for data collection. Slave narratives also provided primary data. Annual reports of the South Carolina Board of Health and conference proceedings also provided sources for data retrieval.

Secondary sources are documents written by others about the research area. Items included as secondary sources are books and documents.[12] Therefore, books and documents of relevance to midwifery and African American health care were used as secondary sources for data collection. As it is important to have information about the documentary materials relevant to the interviewee's experiences, secondary data sources can serve this function.

Sources of Data for the Study

In order to obtain primary source information from African American women who practiced as midwives during the decades of 1950-1970, the investigator interviewed

the study participants to provide a description about midwifery practice in a rural South Carolina community.

To the greatest extent possible, the investigator obtained documentary information about health care and legislation affecting care, access to care, training of midwives, and records of midwifery training. Documents about health facilities, legislative activity and the prevailing economy in South Carolina were studied by the investigator to obtain additional information about other influences on midwifery in the state.

The role of the Board of Health in the county and the state was examined to obtain information about regulation and supervision of midwifery in South Carolina. This documentary information provided a basis for understanding the environmental, economic, and political factors occurring when these women provided care.

The participants descriptions of their experiences as lay midwives provided data critical to understanding what it was like to be a midwife during the time period of this research. Archival sources furnished credibility for dates and types of training these women described.

Archival Sources

The location of materials and documents used for the study involved a number of sites and resources. The investigator located records of the Children's Bureau and its policies about maternal-child programs at the University of Maryland Government Collections Section at College Park, Maryland. The investigator located information about Negro health in the South at the Howard University Moorland-Spingarn Research Center in Washington DC. and the American Memory Collection at the Library of Congress. The National Archive Collections in Greenbelt Maryland provided records of

legislative actions used in this study. The Waring Historical Library in Charleston, South Carolina, Archival section, provided copies of the Annual Reports of the South Carolina Board of Health dating from 1915-1970. The South Carolina Archives and History Library in Columbia, South Carolina provided sources of data on midwifery meetings, and Executive Committee meetings of the South Carolina Board of Health.

The investigator reviewed Health Department records and documents from the state of South Carolina to obtain information about the rules and regulation of midwives at the state and local level. The investigator reviewed past issues of the Georgetown county local paper to identify articles relevant to this research.

Research Variables

The variables identified for study in the research included the following:

1) the personal experiences and daily activities of African American midwives engaged in providing care in South Carolina between 1950-1970 as operationalized via their descriptions of their feelings, behaviors and activities as midwives
2) the history of the field and factors of relevance to midwifery in South Carolina between 1950-1970 as operationalized via official records and other forms of archival information as well as books and articles focused on midwifery
3) African American heath and the structure of the health care system available to African Americans in the United States between 1950-1970 as operationalized via archival information as well as relevant books and articles on African American health and the health care system used by African Americans in the United States

Description of the Sample

Three African-American women who were midwives from 1956-1970 who reside in South Carolina were identified and agreed to participate in the study. The investigator gave an oral description of the purpose of the study to each participant and obtained verbal consent from each subject prior to participation in the study. All participants were informed of the purpose of the study and study procedures and of any potential risks.

The investigator informed each participant that participation was voluntary and they could withdraw from the study at any time without any consequences. The investigator also informed each participant that if the content of the interview caused any emotional distress, they could stop the interview at that time and could refuse to answer any question.

E.R. was a midwife for 10 years and could recall details and particular events extremely well. The youngest of the women, she is now 79 years old. She lives in the same house as when she took midwifery calls. She has eight children, seven of whom were delivered by a midwife. She says her reason for having most of her children at home is:

> I liked having my babies at home because at home they wait on you to have the baby, but at the hospital they take the babies cause the doctors don't have time to sit around and wait.[13]

She lives with her husband and actively gardens, attends church activities and in her words "helps the senior citizens".[14] E.R. provided her own transportation to see clients. She describes driving her truck down many dark county roads at night with her bible, midwife bag and gun as her companions. She says she became a midwife in 1956 because:

> at the time money was tight and you couldn't find work. I studied to become a midwife because I was able to and willing to work. I was about 35 when I started. I enjoyed it. We did not have money. You know how you don't have any money to pay the bills. There was not too much available. We had almost no money at that time. I thought this would be a good way to make ends meet. We had to pay to go to school. Well, it wasn't too bad how much you had to pay, but it was money just the same.[15]

I.G. is now age 86. She lives alone in the same house as when she became a midwife. She depended on her husband for transportation to deliveries. She admits to being a little frightened about the idea of becoming a midwife in 1954 but says "she soon got the hang of it". [16] She notes with pride that she delivered mostly colored babies, but some white ones too. She describes her decision to become a midwife in this manner.

> I don't know, it just come to me. I was dreaming about having my own baby. And I just keep on dreaming it. And I just keep on dreaming I was having it I would wake up at night, and I would say now what in the world is this. And so my sister-in-law say well, the time so tight lets go in for a midwife. I said well all right.[17]

I.G. recalled the granny midwife who delivered her babies.

> My midwife dead now. Old lady name Mrs. Anna live about four miles from here. She delivered about all of my kids. About every one they would send and get her and she would come, cooking such as we had to eat. She would cook and kind of keep things straight in the house. [18]

Midwife I.G. was able to give details about complicated deliveries she attended. However, she was very brief in providing details about any other aspects of her experiences as a midwife. She does not work outside her home currently, but is active in her church and activities at the local Senior Center. She lives alone and does not drive, but relies on relatives for transportation. She says that through her earnings she was able to educate her six children, one of whom is a high school principal in a Northern city.

I.L. is now 99 years old. She did not have any children. Midwife I.L. is the eldest of the midwives. She recalled going out on deliveries, but tended to ramble when

discussing other experiences as a midwife. She lives alone and gardens regularly and is active in church organizations. She has pictures of herself in a midwifery uniform and still has her midwife bag. Her husband died one year after she became a midwife. She relied on the family of the laboring woman to come and get her when she was needed for a delivery. She says that she had a house fire when she was a midwife and she lost everything.

> I got burnt out when I was a midwife, and I been struggling through ever since. I did midwifing about twenty years? Twenty years and my husband been dead twenty-one years. So you see I'm getting old. Well I stopped in seventy-eight.[19]

These women collectively delivered more than 1,000 babies by their accounts as they carried out their roles as midwives. The three women received training at one point from the same "granny" midwife who evaluated their abilities to deliver babies before recommending them for midwifery training.

The women interviewed are now ages 79, 86, and 99. Two of these women are widows. All three women attended training together. They continued the tradition of lay midwifery in their communities after the hospital opened in Georgetown, which was approximately 35 miles from their rural community. The women interviewed for this study opted to become midwives for a variety of reasons. Their descriptions of midwifery care are as valued as their motivation to become midwives.

Data Collection

In data collection, the investigator sifted through materials to determine what was of value and what was relevant to the study. External and internal criticism was used by the investigator to determine the reliability and validity of the data.

The investigator used external criticism to answer questions of where, when and by whom the document was produced.[20] External criticism aided the investigator to examine the origin of documents to identify purposes of documents, when and where documents were written and the authorship of documents.

The investigator determined authenticity of documents before determining whether the information in a document was reliable. External criticism included determining authorship of documents, evidence of dates of documents, and identifying the original forms of documents used in the research.

Internal criticism aided the investigator to determine the reliability of the information collected. Internal criticism questions the accuracy, meaning and credibility of the contents of documents.[21] Internal criticism was used with Annual Reports of the State Board of Health, the South Carolina Code of Law, and minutes from midwifery meetings.

The analysis and synthesis of the data involved reviewing the data thoroughly, categorizing the data according to topics or themes and then writing the narrative that results from the interpretation (analysis and synthesis) of the data.[22] Synthesis was necessary to develop the narrative. The task was to take the many fragments of information collected and organize them in a logical sequence with clarity, flow and without omissions or gaps.[23] The investigator had to be careful to not include bias or subjectivity in the data interpretation. The objective evidence and facts provided the foundation for understanding the past but interpretation by the investigator provided the perspective and views that add to an understanding of the past and raises new questions for study.

Data Collection Techniques

Consent was obtained before the collection of information from the participants (See Appendix 5). The researcher collected information through audio taped interviews. The interviews were transcribed after the interview. The researcher developed the questions included in the interview on the basis of the research questions guiding the study and variables under investigation:

1. Tell me about yourself?
2. Tell me about your earliest memory of witnessing a birth?
3. Tell me about how you decided to become a midwife?
4. Tell me how you felt about the training you received to become a midwife?
5. Tel me about whether any other women in your community influenced you to become a midwife?
6. Tell me about how you helped women to deliver babies?
7. Share with me how people in your community felt about you and your job as a midwife?
8. Tell me about problems you had with some deliveries?
9. Tell me how did being a midwife affect your family?

Data Analysis

The source of the data analysis was the data collected during the interviews with each of the study participants. The investigator reviewed the transcripts to determine similarities of content among the women's' descriptions of their experiences. The data was sorted into categories and examined for patterns and themes.

Limitations of the Study

The participants were three women who were lay midwives in rural South Carolina in the years 1950-1970. The conclusions cannot be generalized to all African American women who were lay midwives.

Ethical Considerations

The protocol for this study, interview questions and informed consent form were submitted to the University of Miami Institutional Review Board that is responsible for the protection of human subjects. The IRB Board deemed this research exempt from a full IRB review (Appendix 5).

Nursing Implications

The documentation of these women's experiences provides a mechanism to describe the contributions of African American women to health care for childbearing women and their families. The information collected provides a vital link to understanding the perception of these women as to health care needs of childbearing women in their communities and their delivery of health care to African American women during the time period studied. This information also provides an opportunity to learn about an essential component of rural health care during the decades for this study.

Summary

Within this Chapter of the study, the research methodology utilized within the study was presented. The research questions were reviewed. The research design and research methods were discussed. The sample for the study was described. An overview of the data analysis methodology was provided. Assumptions and limitations associated with the study were addressed.

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10. Ibid., 3.

11. Glass, 185.

12. Ibid., 185.

13. E.R., interview by Joan Tilghman, March 10, 2001, Hemingway, South Carolina, tape recording.

14. E.R., interview by Joan Tilghman, March 10, 2001, Hemingway, South Carolina, tape recording.

15. E.R., interview by Joan Tilghman, March 10, 2001, Hemingway, South Carolina, tape recording.

16. I.G., interview by Joan Tilghman, March 14, 2001, Hemingway, South Carolina, tape recording.

Endnotes for Chapter Three

17. I.G., interview by Joan Tilghman, March 14, 2001, Hemingway, South Carolina, tape recording.

18. I.G., interview by Joan Tilghman, March 14, 2001, Hemingway, South Carolina, tape recording.

19. I.L., interview by Joan Tilghman, March 14, 2001, Hemingway, South Carolina, tape recording.

20. Robert John Shafer, *A Guide to Historical Method*, Third ed. (Belmont: Wadsworth Publishing, 1980) , 150-158.

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23. Ibid. 359-371.

Chapter Four

Midwifery Experiences

Within Chapter Four, the categories from which the themes are derived will be presented. Subsequently, a detailed discussion of the themes will be provided. The research questions for the study were as follows:

1) What were the personal experiences of midwives within the African American community in South Carolina during the decades of 1950-1970?
2) What factors influenced African American women in their decision to become midwives?
3) What were the training experiences of women who chose to be midwives and how did they describe their training?
4) What were the experiences of midwives in helping to deliver babies during this time period?
5) What was the nature and types of problems they experienced with some deliveries?

The research questions were answered in thematic categories.

Georgetown County

The midwives interviewed for this study attended local midwife meetings and obtained supplies and equipment in Georgetown, the county seat. Georgetown is a historic southern city with moss-covered oaks lining many of the streets. The city is considered a port as it lies at the confluence of four rivers. There are more than 50 homes, buildings, and public sites located within Georgetown that are listed on the National Register of Historic places.

The largest employer in the city is the Southern Kraft Division of the International Paper Company, which began production in 1942.[1] The mill employed African-Americans as laborers and provided a stable income other than farming. In 1962, the mill employed 2,350 persons.[2] The mill also aided landowners who could sell timber to the mill for processing into paper. None of the midwives interviewed for this research were married to men who had worked at the paper mill.

"I farmed every bit of land we had, and worked in a woman's house. I had to do it. He would plant a farm but he didn't make no money out of it".[3] As is clearly identified by this woman who participated in the study, as farming failed to provide sufficient income to support a family, domestic work was an example of the type of employment available to her. Women in general had few job opportunities and Black women even fewer than white women. Rural Black women found employment mainly as domestic labor and tenant farmers. Southern Blacks ranked among the poorest people in the United States.[4]

During the 1950s, the population of Georgetown County totaled 31,762 of which 16,856 were Negroes with 56% living in the rural section of the county.[5] The county ranked 31st among 46 counties in the state.[6] The per capita income in Georgetown was $1,042 compared with an average state per capita of $1,538.00.[7] The county population in 1960 was 34,798 of which 18, 137 were Negroes.[8]

The participants in this study did not complete high school and their options for employment were, therefore, limited. Furthermore, as a consequence of living in a rural community, few occupations were open to them. Farming was the principal means by which many rural Blacks made a living. As reported by the women participating within

the study, they also farmed in addition to being midwives. According to information provided by them, midwifery provided access to opportunities to earn additional money. Although two of the women cited different reasons for their decision to become a midwife, economics reportedly remained an influencing factor in their decision to become a midwife.

The categories that can be derived from the data analysis is as follows: accepting the call, spiritual influences, meeting the standards for midwifery, caring for the pregnant woman, community relationships and newborn care. Accepting the call to midwifery relates to this field of work as a cultural tradition. Using the information provided by the women who participated in the study, their decision to become midwives and their brief apprenticeships with an elder midwife will be discussed. Meeting the requirements relates to the state-mandated rules and guidelines for lay midwifery practice in South Carolina. Requirements for certification as a lay midwife included attending the Midwifery Institute, keeping records of each birth, and maintaining a properly equipped midwife bag.

In providing midwifery care for the pregnant woman, women who served in this role were involved in many aspects of care giving. Care giving for the pregnant woman included traveling to the homes of pregnant women, monitoring women to determine if they were receiving prenatal care and assisting with labor and delivery. This included decision-making and managing complications in labor and delivery, use of home remedies and laboring women and community relationships. Encompassed within the context of midwifery care was the relationship between the midwife and the community.

The midwives in this study will be identified by the following initials Mrs. R., Mrs. G. and Mrs. L.

Accepting the Call: Midwifery as a Cultural Tradition

Midwifery can be considered as a tradition among rural Blacks because it was a practice deeply embedded in the culture of rural Blacks. Lay midwifery has been described as a cultural relationship that existed between the midwife, the pregnant woman and the community.[9 10]

The midwives in this study were considered part of the new order or new type of midwife. Granny midwives initially brought under state supervision in 1919 based their practices on methods learned through apprenticeships. By 1950, those midwives who were recognized as granny midwives no longer practiced. With the emergence of state mandated training programs for midwives, a new kind of midwife was manifested within communities. This new midwife was prepared with scientific knowledge and training in the methods of assessing the pregnant woman for problems during pregnancy and having the ability to deliver babies using knowledge obtained through training programs. However, a remnant of apprenticeships continued in the community in addition to state training and supervision of midwives.

Before being accepted to the midwifery training program applicants were required to be observed and recommended by an elder midwife or doctor. The participants in this study all speak of an elder midwife in the community, Mrs. C., who observed their skills at a delivery. Based on her evaluation, a recommendation could be made for that midwife to be admitted to the midwifery-training program. The importance of the elder midwife to the women in this study is borne out in the interviews. As reflected in the

findings, the elder midwife evaluated potential abilities to become a midwife and provided personal counseling for those midwives with whom she worked. The elder midwife would attend a delivery with a prospective midwife to determine if the aspiring midwife demonstrated the capability to deliver babies. The elder midwife would then make a recommendation to the doctor at the Health Department for the applicant to be admitted to a midwifery-training program.

Mrs. G. discussed how apprehensive she was about delivering babies. Mrs. G. wanted to observe a delivery to help decrease some of her anxiety. She requested the elder midwife contact her when a delivery was imminent so that she could observe. The elder midwife contacted Mrs. G. and they both went to the home of a laboring woman.

After reaching the home, the elder midwife decided to let Mrs. G. assist in the delivery. The elder midwife provided coaching by telling Mrs. G. what to do as the delivery progressed. As reported by Mrs. G. the opportunity to assist the elder midwife during a delivery helped decrease her anxiety and confirmed her decision to become a midwife. Her performance was the basis for the elder midwife to recommend Mrs. G. for admission to the state midwifery training. Mrs. G. describes her feelings about the recommendations by the elder midwife

> And I delivered the baby; oh she just praised me and tell me I did a wonderful job. And we use to go to meetings at the health department too. And she got up in there and told them what a wonderful person I was. She recommend me to the highest people down at the health department. And then from then on I was able to go to the training.[11]

Through her role as an experienced midwife, the elder midwife provided an opportunity for others to become midwives based on her recommendations. Research by Beatrice Mongeau with lay midwives in North Carolina during the 1950s revealed a

system of midwifery that represented a cultural tradition in which prospective midwives were selected by a practicing midwife.[12] The usual mode of selection was for a current midwife to select a family member be it a sister, daughter or other relation to succeed her.[13] In cases when there was not a family member to succeed a midwife, another woman in the community would be selected. As reported by the women who participated in the study the opportunity to become a midwife did not occur based on familial relationships. Mrs. G's admission to midwifery training was based on her personal request and the elder midwifes' observance of her skill in assisting with a delivery.

Based on information provided by Mrs. R., the accord given elder midwives in the selection of midwives for the community is further documented. Mrs. R. recalled having to work with the elder midwife before being able to obtain a recommendation for the midwifery-training program. Mrs. R. felt that she learned a lot from the elder midwife and considered her lessons from the elder midwife as important as those lessons learned while she attended the Midwifery Institute.

As identified by Mrs. R., the critical lessons she learned from the elder midwife emphasized the importance of being prepared for emergencies. Mrs. R. considered the advice of the elder midwife relevant because in the community there was limited access to a hospital or doctor. As well, as reported by Mrs. R., the elder midwife helped her obtain work as a midwife by referring her to five women who would need services of a midwife. Furthermore, the elder midwife provided mentoring for potential midwives in the community in many ways. The assistance provided by the elder midwife to midwifery students at the training program was not about delivery procedures, but more geared to help new applicants adjust to the environment at the Midwifery Institute.

As reported by Mrs. L., she only went to school with the elder midwife for one year. The assistance provided by the elder midwife was helpful in developing an understanding of lessons in the manual as well as learning new terminology about labor and delivery. In addition, the elder midwife provided counseling to help Mrs. L. avoid a personal confrontation with another midwifery student. The elder midwife cautioned Mrs. L. about the need to stay out of trouble and not argue with a fellow student as any behaviors that resulted in disciplinary actions could lead a potential applicant to be dismissed from the program. In the fulfillment of her role, as was reported in the study, the elder midwife made an effort to prevent students from her area from experiencing problems that could influence their dismissal from the program. In the following statement, Mrs. L. described how the elder midwife helped her resolve a potential conflict.

> One woman there so mean to me. She was the meanest woman I ever saw in my life. Mrs. C. sleep down the deck below me, and I sleep up. I said Mrs. C. She said what you want baby? I said that woman is so mean. She said you leave that woman off. I said I ain't bothering that woman. That woman made me cry. Oh, I don't like for nobody to make me cry, and Mrs. C. helped me to pray about the situation so that I would be able to go on.[14]

Spiritual Influences

Within historical accounts of granny midwives, frequently one finds descriptions of the calling to be a midwife based on a spiritual influence. Spiritual influence is reflected in each of the interviews conducted within the study as the women recount how they depended on God to help them in difficult deliveries and with all problems they faced. As one midwife discussed her decision to become a midwife, her story evoked a mystical quality when she described dreaming about having a baby. As she described it, she kept on dreaming about having a baby as if there was some type of subliminal signal

or spiritual force influencing her decision. After the dream persisted, she answered her perceived call and convinced her sister-in-law to attend midwifery training with her.

The organizers of midwifery training programs apparently recognized the importance of spirituality for women who attended training. The experience of and identification with spirituality was used in the midwifery training programs to enforce teaching and midwifery guidelines. The midwives were taught songs while at the Institute to help them remember to wash their hands and to complete the birth certificate forms. These songs had the same rhythm as Negro spirituals and were such that through the use of song, women were encouraged and better able to remember the words. As further evidence as to the use of spirituality within training programs, the midwife manual featured a prayer in the preface (Appendix 6). Each morning at the Institute classes began with prayer. In the midwives prayer, acknowledgment is made of the importance of God as the source of life. In interviews, the midwives spoke of the relationship of God in their lives and how their existence and work depended on God.

Mrs. G. spoke of total dependence and faith in God for helping her to be able to deliver babies safely. She credits her faith in God as the basis for being able to have safe outcomes for the women she cared for. Mrs. G. felt all her actions, including what she was taught at the Midwifery Institutes, depended on her faith in God. She felt that none of the babies born to mothers she delivered died because God helped her. However, she did not imply that a tragedy occurring to the mother and/or baby during delivery was indicative that God did not bless the midwife assisting with the birth. She described her faith as total and complete. "Cause I didn't believe in nothing but God. I believed in God to help me with my patient. I believe in God for everything". [15]

Mrs. L., who was the oldest of the midwives in this study, described her midwifery practice as being dependent on the will of God. She credited her longevity to her prayers and faith in God. As reported by Mrs. L., while attending the training program, she found the lessons difficult. She completed three years of elementary school and although able to read and write, she experienced difficulty comprehending the meaning of many words in the *Midwife Manual*. She struggled to master the terms and to pass the written tests. She studied with the elder midwife and was successful in completing the training program. She described her studies as being difficult and her successful completion of the training program due to God.

> And when I was at the school tryin to learn to be a midwife, I had some hard times. And the lessons were hard, and I had to study. Mrs. C. helped me with some of the words, and I tell my sister-in-law, I blame you for making me come to this school, and she say Oh you'll be alright. I read my bible and say Lord help me. Oh, I had a time. I believed in God to help me with everything. And God help me every time.[16]

Meeting the Standards-Midwifery Training

Midwifery Institutes served to institutionalize lay midwifery and assure conformity to Board of Health standards. The state Board of Health used the mandated training programs to aid in promoting safe and hygienic care to laboring women and to newborns. After attendance at these programs, midwives had visible symbols of legitimacy. Midwives in the community were required to wear uniforms and carry their midwifery bags with appropriate equipment to all deliveries. As representations of legitimacy, these actions provided the community with a means of knowing that only certain women were capable of becoming and practicing as midwives. Because of their training, midwives considered themselves more advanced in knowledge of pregnancy and childbirth than their predecessors. Thus, attending the Institute was a visible reminder to

themselves and others in the community that they had participated in training different from previous midwives.

When these midwives attended Midwifery Institutes, a manual entitled Lessons for Midwives was used for classroom instruction. The manual contained 15 lessons for midwives.[17] The lessons provided a science-based framework for care to be delivered according to Board of Health guidelines. The Manual also listed state expectations of all midwives. The first lesson stressed the importance of a midwife as well as personal characteristics for a midwife. Based on guidelines from the manual, characteristics of a midwife included physical hygiene, personal reliability, respected by others, adequate physical strength and even included instructions such as the midwife should keep her underclothes clean.[18]

Because the lives of the newborn and mother depended on her care, the midwife was deemed important by the State Board of Health. Lessons consistently built on the premise that all midwife actions were done to preserve the health of the mother and newborn. The midwives attended class sessions at the Institute and were graded on performances and memory of content. The aim of the Institute was to teach midwives how to provide the safest level of care for women in labor.

The women in this study attended midwifery training at the Penn School. Located on an island in Beaufort County, Penn School was established as part of the Port Royal Experiment in 1862 by the abolitionists of Pennsylvania and a group of churches.[19] The Penn School provided classes for midwives in addition to teaching crafts to African-Americans. The midwives in this study all traveled to the county seat, Georgetown and met at the health clinic where a bus transported them to the Penn School. After arriving at

the Penn School, women were assigned to dormitory rooms and provided with midwife manuals.

African American women from many counties in the state attended the program. At the start of each day during the two weeks of the Institute, midwives, dressed in uniforms, formed lines and marched into an auditorium where they met for morning devotions, including recitation of prayers and the pledge of allegiance. After devotions, breakfast was served and after breakfast, classes began.

All of the midwives recalled lessons taught from the Manual. They recall the 70 page Manual as being difficult to understand. As a consequence of the difficulty associated with the Manual students recognized the importance of listening to the teachers, which was perceived as helpful when they could not understand what was written in the manual. Mrs. G. recalled studying for long periods to be able to learn the material. She was proud to be accepted into the training program and considered going to school as important. She remarked: "I studied my lessons real hard, I went and learned the lessons. I didn't go to school just to be going, I went to listen and look and find out what's going on".[20]

The students paid for the two-week training session. At the school, the midwives practiced delivery techniques using a mannequin and "dolls" to demonstrate newborn care. The midwives had to demonstrate how to prepare a room for a delivery with all necessary equipment. The demonstrations included how to set up a delivery room using material from the patient's home. These simulated cases helped increase students understanding and allowed the teachers to evaluate students' ability to prepare the room for the birth. While in class, students practiced all aspects of care giving for a laboring

patient, and care for a newborn. The ability to perform care-giving measures under the evaluation of a public health nurse was a means of confirming whether the midwifery student could be safe providing care for a laboring woman and newborn. The mannequin used in class was referred to as "Mrs. Chase" and the students were expected to treat the mannequin as a real patient in simulations of care. One of the midwives recalled lessons and the use of the mannequin in the classroom.

> The classes were pretty straight on what you could do and what you couldn't do. Oh we would practice. We delivered doll babies. And, we put the drops in their eyes. First we delivered, and then we put the drops in their eyes. I tell you we had to practice delivering them babies and put Mrs. Chase to bed. She be laying up in there with that baby in her arms. We would go in the morning and we would have to act like the dummy was a real person. Mrs. Chase, you would ask well how you feel this morning? Somebody would say oh I feel all right. I'm feeling fine. And we would go back through the same thing. The same thing everyday, and you can't drop them babies. You got to act like it's a pure live baby.[21]

Meeting the Standards-Record Keeping Responsibilities

The Board of Health sought to impress upon the midwives the importance of accurate record keeping and prompt reporting of births. The state had a long history dating to 1915 of difficulty obtaining accurate data about births.[22] South Carolina was a participant in the national initiative to register each birth so that accurate information could be provided about birth rates and infant and maternal mortality in the United States. Based on data obtained during study interviews, it is clear the importance of record keeping and reporting birth information became ingrained. Through serving as a community referent, the midwife became a valuable repository of information. The importance associated with a birth certificate provides an example of how midwifery served purposes other than assisting with labor and delivery. The women in the study

described situations when their assistance was needed to provide proof of a child's birth. Official records of each birth were maintained at the state Vital Statistics Office.

As Mrs. L. reported, she kept a record of every baby she delivered. She remembered the words to a song taught at the Institute about the importance of filling out the paperwork for the birth certificate. On the last day at the Institute, all midwives learned a song about the importance of completing the birth certificate because the state required birth certificates and a child could not enter school without proof of birth. Midwives were encouraged to remember the song each time they went out to deliver a baby. Mrs. G. remembers the words to the song and recalled:

> We know it is important, a real standard rule. He'll need birth registration to enter any school, to prove he is the right age to marry or to vote. So be sure his birth date you will report.[23]

During the study interviews, all of the midwives recalled the importance of completing the birth certificate and turning them in as soon as possible. All births were to be reported within one day after delivery. The birth certificates could not be mailed as they had to be taken to the health department and given to the county public health nurse supervisor. Midwives complied with mandatory birth certificate registration because it was a practice requirement and provided a service to their community. When a parent lost a birth certificate, a copy could be obtained based on records from the midwife. Mrs. G. recalled being able to provide proof of birth to many people in her community.

> Some people would could come back to me and get me to help them if they lost the birth certificate, because I had a record of every baby I delivered. Sometimes when a child would start school and the mama had lost the birth certificate they would come to me to get a copy of the birth certificate.[24]

Meeting the Standards-Having the Necessary Equipment

In Lesson XI of the Midwife Manual, the subject was "Contents, Arrangements and Care of Midwife's Bag".[25] In referring to the midwife, it is noted that: "she should be proud to know that she carries in her bag the drops that help keep the baby from going blind and that she knows how to keep clean so that she can prevent infections for the baby and the mother".[26]

The bag was a symbol of legitimization for the midwives. Professionals with whom the midwives came in contact all carried bags which were emblematic of their profession. The doctor carried a medical bag on his home visits. The public health nurses carried nursing bags with equipment needed for home care. The midwife bag, which was a leather satchel, could only be obtained after completion of midwifery training.

Lessons about the midwife bag stressed the importance of having the bag ready at all times. Classroom lessons began with instructions about how to prepare the bag and what supplies to carry in the bag. The bag had four compartments or pockets in which equipment could be kept. The midwives had to carry an orange stick, a nailbrush and a soap container for hand washing. Cotton balls in a glass jar were carried to cleanse the area around the vagina before deliveries. Equipment in the bag for the newborn included scissors, sterilized cord dressing, silver nitrate drops for the eyes to prevent neonatal blindness and baby scales. An enema pan was included with folded newspapers for bed linings, a basin to boil equipment in, and a pack containing a scrub gown, cap and towel comprised the remaining contents of the midwives bag. Mrs. G talked about her bag in this way:

> If you use that bag, then you have to get it ready for the next time you have to go out on a call. Sunday sometime you're at the church, you got to leave the church, come on home and get that bag and go.[27]

Caring for the Pregnant Woman-Getting to the Homes

Living in a rural community with limited means of transportation could pose difficulties for the midwife to get to the home of a woman in labor. One of the midwives drove to deliveries while the other two midwives relied on others for transportation. Mrs. G. depended on someone for transportation. Often a family member came to get the midwife for a delivery. The midwife might have to stay overnight in some cases. Mrs. G. always preferred to stay at the home of the laboring woman and return home during the daytime. She frequently went out on calls that were false alarms. She described conditions in which the houses were poorly heated and she had to keep her coat on until it was time for the delivery. Midwives frequently had to take food because there might be limited food at the house of the laboring woman.

Mrs. L. also relied on others for transportation to the homes of laboring women. Either her husband drove or a family member of the patient she cared for provided transportation. On some occasions, there would be more than one patient needing the services of the midwife. In such situations, Mrs. L. reported that she would have to leave one home after a delivery and go and deliver another patient. Mrs. L. recalled leaving home to take care of one patient and being called to the home of another laboring patient. Midwives were required to remain at the home of any woman they delivered to make certain that there were no problems with the mother or newborn.

> And sometime I be at one person's house and there is somebody at the door calling for me to go to their house and wait on their wife. But now if it's not too close, I wait on that one I am with, then go, wait on the next one and when we deliver a baby we not suppose to deliver a baby and then lay the baby down and just walk out. We suppose to stay there a certain length of time to see if that mother get along good before we leave and go somewhere else.[28]

Mrs. R. drove a truck to all her deliveries. Consequently, she felt more in control of getting to her destination because she did not have to rely on anyone for transportation. She spoke of her best companions being her midwife bag, Bible and pistol. She needed the midwife bag for deliveries, the Bible for spiritual support and the pistol for personal protection. She regarded the pistol as important as the midwife equipment.

> I would work hard and I would keep something to drive so I wouldn't have to bother nobody else. It is better than to get in a car with somebody else and go. When they come and engage me to deliver that baby, I drive myself. I take my pistol with me whenever I leave home late at night so I was ready in case something happened. I never had to use my pistol, but I wasn't scared to use it. I mean living out in the country like this and a woman out on the road by herself. You just don't know. Something could have happened to me and nobody would have known about it. [29]

Caring for the Pregnant Woman-Verifying Prenatal Care

Midwives were only allowed to take normal pregnancy cases for deliveries. Any women opting to use a midwife for deliveries had to be examined by a doctor by the fifth month of pregnancy. After the doctor performed an examination, he would give the woman a card stating that she had been seen by a physician and could now engage a midwife for further care.

After the midwife agreed to take a case, the midwife made a home visit with subsequent visits at the 7th month and the 9th month. The first home visit helped the midwife to learn as much as possible about the home, family and general living conditions. During the initial visit, midwives would discuss payment for delivery as well

the need for the patient to go to the prenatal clinic at the local health department or see the doctor once a month. Midwives were encouraged to accompany their patients to the clinics for the first clinic visit.

At the second home visit, the midwives were to observe patients carefully for any danger signs of pregnancy such as bleeding, headaches, sudden weight gain. Danger signs of pregnancy were taught in lessons at the midwife institutes. If a woman described experiencing any danger signs of pregnancy, the patient would be advised to report to the clinic nurse for further evaluation. Making arrangements in cases of emergency was an important part of the second home visit. Husbands were told that they needed to be at the home at the time of delivery in case the doctor had to be contacted. One of the midwives in the study described the process that had to be followed for a pregnant woman to engage a midwife for care.

> The doctor would give the woman a card after he had checked her out to make sure a midwife could deliver them. The doctor had to check them out first, and doctors gave the women cards to prove they had seen a doctor. The card had to be carried and they took that card to the doctor to keep check of them. And they give me that card, and I look at that card and see if they were doing all right. If they didn't have their cards I wasn't supposed to wait on them. I was just supposed to let them alone.[30]

During the 8th month, midwives, at the time of the home visit, were to check on the patient's condition and verify that prenatal visits were continuing with either the doctor or the health clinic. During this visit, the midwife would instruct the mother about having clothes for the baby, how to prepare the room for a delivery, and obtaining supplies for the delivery. The midwife would make two large delivery pads of newspaper and muslin that would be use to protect the mattress. Another newspaper pad would be

made for packing the placenta or afterbirth. These supplies were to be kept in a clean place until the time of delivery.

Caring for the Pregnant Woman-Assisting with Labor and Delivery

The importance of being prepared as well as knowing how to care for the mother was an important component of midwifery training. Midwives received specific instructions on the physiology of pregnancy and the maternal and fetal changes occurring before delivery while at the Institute. As well, focus was directed to the care giving responsibilities of midwives during childbirth for the mother and baby. The Midwife Manual specified how to prepare the room, prepare equipment, deliver the baby and care for the baby afterwards.

Mrs. R. reported that she felt she was fortunate in that she did not have many problems with caring for patients. She considered some deliveries extremely easy. Such was the case for a pregnant woman whose husband came to get Mrs. R. one night and insisted she hurry because the delivery was imminent. The woman in labor had delivered 4 children previously. When Mrs. R. arrived at the home, the laboring woman was calmly rocking in a chair. She instructed the midwife to get the bed ready and let her know when she wanted the baby to be born. Mrs. R. prepared a basket for the baby, helped the woman get in the bed, and after a few grunts and pushes from the laboring woman the baby was born.

When preparing for a delivery, certain procedures were followed. From the time the midwife received the call to come to a laboring woman's' house, she organized her plan of management. She left her home wearing the uniform with midwifery bag in hand. Upon arriving at the home of the woman in labor, the midwife put a gown over her

uniform and covered her hair with a cap. Before the delivery, water would be boiled and the pan or basin would be used to sterilize equipment.

Caring for the Pregnant Woman-Management of Complications

Midwives received instruction at the Institute as to how to care for a woman if complications developed. Midwives were expected to observe for complications such as bleeding. By report, midwives in this study admitted to few complications and stated what actions they took to provide safe care to women in labor. In describing their experiences, they reported that they knew the doctor had to be contacted when a complication arose. During study interviews, complications reported included breech deliveries and a few other difficulties.

Other complications reported included seizures. One of the midwives remembered arriving at a home while the laboring woman was having a seizure. She knew she was not supposed to care for a patient with seizures; however, as she noted:

> And when I walked on in the door and washed my hands to get ready there was the woman with seizures. We wasn't suppose to be delivering women with seizures, but what can you do? So I delivered the baby and the woman, she calmed down. I put a spoon, put a piece of paper over the spoon, put the spoon under her tongue, to keep her from biting up her tongue.[31]

One of the midwives recalled delivering what she called a "waterhead baby" on two different occasions. One of the babies died while in the hospital, the other baby died at home. The midwives were not supposed to deliver any babies that posed complications for the mothers. Babies born in the breech position were to be delivered by a doctor. However, based on information obtained during the interviews, it appears that frequently there was not time for the doctor to arrive to deliver an infant presenting in a breech

position. At other times, the midwife did not know the baby was in the breech position until birth was imminent.

In cases where the midwives felt the only option was to deliver breech presentations, they reportedly were able to proceed calmly and deliver the baby safely. When referring to such deliveries, the midwives used the term "foot formers". All of the midwives admitted to having to deliver "foot former" babies. Techniques used by the midwives were methodical and appear to have proceeded without difficulty. Mrs. G. described her techniques for a breech delivery. She said:

> See we were not suppose to deliver foot form babies (breech deliveries). But I had a lot of them. But I didn't know that until I would get there. And there was the two foots, I said what is this? Then I catch myself and say oh, and then there was the baby. I just let the baby come on. You're not supposed to pull on the baby. Them pains will bring that baby out. And then when the baby is coming you suppose to take your right hand and calmly, run your hand beside the baby head to see if the cord wrapped around the baby neck. And if its wrapped around the baby neck you take your hand and real easy like slip the cord over the babies head, but sometime the cord chokes the baby to death.[32]

One midwife appeared to believe that babies delivered feet first were different than other types of babies delivered vaginally. She stated:

> But you know there is something in those foot formers. That's something in them they have more sense than the rest of babies. [33]

The importance of lessons learned from the elder midwife strengthened Mrs. R. in her resolve that she could deliver a "foot former" delivery.

> There was one lady down the road. She said to me I don't want to go to the hospital. She crying and wouldn't tell me why she was scared to go to the hospital. I wasn't supposed to wait on her, but she was foot forming. The old lady Mrs. C. teach me what to do though. I did not want to learn that, but the old lady said you better learn cause, you ain't going to be able to get a doctor or something, so I say I better learn. I had to do that, the twisting you had do for up to five minutes. I have to get the two little feet to come out first. We were all right because I know how to do it. You don't turn them babies around. You keep

> on twisting the feet. You keep twisting them until the head comes out. That is how you got the baby. Then you have to wait until the afterbirth comes.[34]

Caring for the Pregnant Woman-Decision-Making in Care Giving

As the data from the interviews suggest, midwives who found themselves residing in a rural area approximately 30 miles from the nearest town often had to make decisions regarding the need for medical assistance. The training at the Institute and their previous experience aided their ability to make decisions about care for their patients. Incidents in which a patient was bleeding indicated to the midwife that a doctor's care was needed.

Midwives felt no hesitation about calling the doctor if they suspected a woman was having complications. Mrs. R. remembered calling the doctor for a laboring woman with only ten dollars to pay for care. Mrs. R. contacted the doctor and told him the woman was bleeding badly and only had ten dollars. Mrs. R. remembers the doctor living about 15 miles from her. She recalled that the doctor would always come when contacted. Due to absence of a telephone, Mrs. R. would have to send for the doctor. The doctor would come and deliver the baby for 35 dollars. In cases when the placenta (afterbirth) was not delivered, midwives said they knew there would be problems. When the placenta did not deliver spontaneously, the midwives called the doctor for assistance. Some of the situations discussed by the midwives in the study were not included in the Midwife Manual. Mrs. R. described a case in which a young woman seemed to have experienced a severe case of depression. In this particular case, an unmarried young woman did not want to live. The young woman (a teenager) provided a prenatal card for the midwife to verify. The young woman's mother was deceased and she lived with her father and stepmother. The young woman was depressed and confided to the midwife that she did not want to live. Without giving any reason to the midwife, the patient said

she stopped going to the doctor because her father and stepmother were talking about her. The girl was unmarried and the midwife was unsure who the father of the baby was. When it was time for the When it was time for the woman to deliver, Mrs. R. was summoned and took the woman to the hospital. Mrs. R. knew she could not care for the woman, but felt obligated to take her to the hospital.

> She wasn't married, you know. When her time come she send for me and I did get her into the hospital but she died. The baby lived. See, I sent for the daddy, and I told one of the children in the house I said go get your daddy because I have to take her to the hospital. The child said, daddy won't come. I sent for him and he still wouldn't come. But, I did all that I could do. I wanted her to live, but she wanted to die, but she wouldn't tell me why. She died, but I get her into the hospital. The baby come and everything, but she (the woman) died the next day. I was trying all that I could to get her to live.[35]

Caring for the Pregnant Woman-Use of Home Remedies

The Board of Health sought to educate a new kind of midwife while eliminating the presence of midwives who were considered superstitious or using traditional practices. The use of home remedies was not included in the classes at the Midwifery Institute. Only one of the midwives shared any techniques or actions in care giving that were not taught at the Midwifery Institute.

Mrs. R. remembers giving tea to women for labor pains. She prepared the tea hot and had women drink it while still warm. She would tell the woman the tea would help ease the pains. As Mrs. R. indicated, she believed that if the women failed to recognize that the tea would help then the pain would not diminish. The root she used to prepare the tea grew in her yard but she has been unable to find that type of root for approximately 10 years.

The elder midwife believed it helped a woman in labor if the midwife got in the bed with them. Mrs. R. remembered the elder midwife getting in the bed and taking the

laboring woman's hands and encouraging them to help ease the pain of labor. Mrs. R. felt that the wisdom of the elder midwife was not to be questioned and while Mrs. R. did not employ this practice, she did not refute it.

> Mrs. C. use to get in the bed with the women. She used to take them by the hand and get in the bed. She would do this to encourage them. Some of them ladies would laugh at her, but I figure Miss C. know what she doing.[36]

Newborn Care

In efforts to decrease infant mortality, midwives were instructed in immediate care of the newborn after delivery. This included weighing of the newborn and silver nitrate prophylactics to prevent neonatal blindness in cases of untreated maternal gonorrhea and weighing of the newborn. Silver nitrate drops were placed in the eyes as soon as the cord was clamped. After this babies would be weighed by wrapping the baby in a diaper and using the scale to weigh the baby. If the baby's weight were less than 5 pounds, the baby would have to go to the hospital.[37] Midwives recalled how they cared for the newborn with visits to the home after the delivery. Midwives returned to the home for five consecutive days and then again on the seventh and ninth day after the delivery. The umbilical cord was tied at delivery with a fabric cord. One of the midwives reported that as she was ending her practice, plastic clamps were being used.

As reported within the study, midwives were taught the importance of checking the newborn for signs of infection around the cord or navel/belly button. Midwives were to remove the newborn clothes and assess the cord area. Frequently mothers would have a band of cloth around the baby's waist that covered the cord. The midwives believed the strip of cloth helped to make the back strong and kept the belly button from protruding. Midwives were not supposed to carry baby bands. However, one of the midwives

remembered using a band for her baby. When this midwife took her baby to the health clinic, she would remove the band because she knew the doctor or nurse would check for it.

Community-Relationships-Receiving Payment for Services

While a need existed for lay midwives in the local community, issues associated with payment and expectations of clients regarding midwife services often presented a challenge to community relationships. Lessons at the Midwifery Institute did not focus on payment and collection of fees. Nurse Blackburn, the Midwife Supervisor for the state, noted in a 1941 article that a frequent concern of midwives was about their not being paid for deliveries.[38] It appears that frequently the payment was not cash and at times, there was no payment for midwifery services.

The cost of a delivery was $25.00 when the midwives interviewed in this study began their practice. Midwives sometimes received varying amounts for their services. Mrs. R. describes the difficulty of obtaining pay for deliveries

> We charged twenty-five dollars. And sometime I got twenty-five and sometime I got ten, sometime I got fifteen, sometime I got nothing. But anyway, I went on. I said if you got it give it to me, if you ain't, I'll make it.[39]

Some of the patients would reportedly agree to pay the midwife at the next delivery. As was found during study interviews, midwives believed that the women they cared for should have saved the money to pay the midwife. Pregnant women had to contract with the midwife by the fifth month of pregnancy to arrange for delivery. During the initial visit to the home, the midwife discussed the fee for midwifery services with the pregnant woman; therefore, the cost for a delivery was not an unexpected event. While many valued the services of the midwife, some women reportedly felt it

unnecessary to pay a midwife. One of the midwives spoke of how a patient felt about paying for midwifery care. " One of the woman she give me five dollars. I believe she did. Then had the nerve to tell me I was hardly working. She wanted me to come again the next year".[40]

As reported by one of the midwives in the study, the reason the pay was not always as contracted for was that the people in the community lacked the funds to pay for a midwife and paid as best they could. As she recalled: "Sometimes I did not get paid. Some people didn't have nothing to give".[41] As a result of the inability of some women in the community to pay for a midwife or doctor, maternal deaths occurred. Mrs. R. remarked that some poor women died because they lacked money to pay for services.

> But you see, people didn't have no money. They did not have any money to give, so a lot of people just die during birth. There were a little bit of people that did die during birth that could not get a doctor and they just die.[42]

Sometimes after having stayed up with a woman for more than 24 hours, the midwife would not be paid for her services. One of the midwives in the study recalled how a woman paid her years after the baby was born:

> A lady come up to pay me some money to pay she owed me when her son got grown. She did not have the money for me when I waited on her.[43]

One of the midwives spoke of having a newborn offered to her as payment for the delivery.

> One of the ladies, I started waiting on her, she had about ten or eleven children. She wanted me to take the baby. If I take the baby, then she didn't have to pay. I said this makes no sense for me to have all those children home and take another baby. She was just going to give him away. But, I wouldn't take the baby. I say you take care of your baby and I will take care of mine. She wanted me to take the baby so she wouldn't have to find no money. The baby would have been the payment.[44]

Mrs. G. described circumstances in which she did not receive monetary payment but benefited from a bartering type of arrangement. Some patients would pay with food because the patient did not have the money to pay for midwifery services.

> Some times I would be at the house and they would have some of the biggest steaks you every seen. And then when I go to come home they give me a whole bag of steaks. Some people tried to pay you, mostly with money. [45]

The midwives in this study cared for patients unable to pay and considered it unthinkable to leave a patient who could not pay for services.

> And then I had to I wait on a lady with two other babies. So tell me, what was I to do? I did not have a choice. The husband was there and the baby was coming, I did not have a choice.[46]

Mrs. L. felt that poor planning contributed to patients being unable to pay for services.

> See they had nine months to do something. Yeah, like the doctor said pay me now, you can't owe me. You have to pay me in advance before I do it. And the people could do the same thing. Money was scarce but they knew I was coming.[47]

Community Relationships-Expectations

Whereas granny midwives performed household tasks and stayed with the woman for a few days after delivery, the experiences of midwives in this study were not similar in this respect. As the midwives represented a new order of midwife, they assessed the mother and baby to gauge their health status. However, performing household chores were not a part of the training for these midwives.

Sometimes midwives would have to educate patients about the role of the midwife because some patients expected the midwife to help with household duties. The midwives in this study perceived their practice as different from their granny

predecessors. They considered themselves a different type of midwife and provided care solely for the baby and mother. Mrs. R. explains the change in the following statement:

> Now when I was a midwife I was there to take care of the woman, no I didn't cook and clean for them. I didn't cook and I didn't hardly eat. Just waiting around and helping out with the mother. Sometimes the women expect you to iron like you gone deliver the baby and you gone also take care of the house. I run them away from that. One woman said to me "Well it ain't been nothing done mama's dead". I said well if ain't nothing been done nothings gone get done. She know I had to take care of her but her house that's something else.[48]

Community Relationships-Care After Delivery

Another aspect of care giving and community relationships was the responsibility of the midwife to return to the home of a woman after delivery for what the women describe as after care. During these visits, an assessment was conducted to determine any potential complications or additional needs for the mothers and/or newborn. Mothers remained in the homes for nine days after delivery and the babies were not taken outside the home for nine days. One of the midwives remembered some women staying in the house for two to three weeks. The midwives would assist the mothers out of bed and have them walk around the rooms in the house. After care for the mother consisted of bathing and helping her to ambulate. The baby would be bathed and the midwife would check the cord stump to determine if the area was drying and there were no signs of infection.

As identified by the midwives in the study, the reasons women remained in the home for at least nine days after delivery was because leaving the home too early would lead to colds and illness for the mother and baby. One of the midwives described staying at home for nine days after delivery as a preventive measure for the mother.

> Because if the woman don't stay in the house it turn back on them and when it turn back on them, it gives you colds and you get sick. Things like that. It isn't any good that you just have a baby and then go outside. No, it ain't good.[49]

One of the midwives recalled her grandmother made her remain at home for nine days. The home had board windows and she had to stay away from the windows because according to her grandmother: "A woman who had just delivered could not go out near those windows. Don't you go look out them windows because the sun will burn you".[50]

Community Relationships-Hospital Deliveries

The change to hospital deliveries rather than home deliveries occurred first for white women in the community. In the rural community in which the study participants practiced, midwifery deliveries continued after 1950 even when a hospital was constructed 35 miles away. Until 1950, women went to another county if they chose to deliver in a hospital. For women living in town, a local doctor made house calls for deliveries.

Mrs. G. recalled that many African American women couldn't go to the hospital because they didn't have money. Most white women in the community went to the hospital to have their babies. However, Mrs. G. did deliver some white babies.

> Now a lot of the white people went to the hospital. But the blacks was poor and they had midwives. I think I must have delivered about eight or nine white babies and all the others were black.[51]

Only one of the women in the study had a child born at a hospital. She provided an informative commentary on the merits of home birth versus hospital delivery.

> I had one baby in the hospital, I went to Georgetown Hospital. I feel like the baby born at home is better. I can be comfortable at home. The hospital would charge me, when I could of just go home and lay down. When you are home, you are awake. My child born at the hospital cost more than all my children born at home. They don't give you too much time in the hospital. Doctors give you so many hours. Then they go right on in and take the baby.[52]

As reported in the interviews, the community continued to recognize the midwives after their practice ceased. Mrs. R. would have people come to her home requesting help. A relative asked her to deliver a baby. Mrs. R. said she refused to deliver the baby.

> A relative of mine said to me cousin, if you just help me this time, it would help me. I said I am sorry, but I can't cut the cord even though the baby is here. I said I will tell you what, I will take the afterbirth out and then you take her to the hospital. Well she unwrapped that baby, and cut the cord, but I tell them, I wasn't going to do it. Now the lady was an old midwife, But, she did it. How come I don't know. She didn't do like I asked her to do. I asked her to take the baby and everything right on up to the doctor and hospital and asked them to cut it.[53]

When the women in the study decided to no longer work as midwives, their reasons for retiring from midwifery involved family circumstances and poor payment for services. There was no evidence to suggest that they no longer cared for midwifery. Rather, their reasons focused on time away from family and problems arising over not receiving payment for services. Mrs. L. reported that she found other employment that she identified as nursing. Mrs. L. would stay in the home of sick persons and provide care for them. "I give my patient to another woman because I was nursing. I couldn't do two things at one time. But I done it for a long time".[54]

Mrs. R. cites sporadic payment from patients and having to leave her children as the main influences on her decision to quit being a midwife.

> I miss my children while I was at the school. I liked it all right. I was worried about my children so bad. My older children helped my husband with the little ones. I quit midwifing because I would have to leave them home day and night, until I come back. I didn't want to upset them, so I tell them I will be back. I like it all right. I would keep on going, but just like I tell you, people are slow to pay.[55]

Chapter Summary

Chapter Four has provided a discussion of the categories and themes derived from the interviews with the women who participated in the study. The accounts of experiences in care giving provide a descriptive basis of the rendering of care to rural African-American women during the decades of the 1950-1970. Chapter Five will offer a summary of the research conducted and implications for nursing.

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25. *Midwife Manual,* 55.

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Chapter Five

This study provided a description of the experiences of three former lay midwives who provided care in a rural community in South Carolina. The women in this study attended state mandated midwifery training programs during the years 1950-1970. Physicians and public health officials identified untrained midwives as the cause of high death rates and complications of childbirth resulting from midwifery deliveries. In an effort to decrease the complications associated with childbirth and decrease the mortality rate, the South Carolina Public Health Department initiated strategies to improve maternal and infant health. Public health officials believed midwifery training programs would aid in improving mortality rates, which ultimately would benefit the state of South Carolina.

Legitimization of Lay Midwifery

African American midwives were an integral component of the health care delivery system for rural pregnant women. The training programs for lay midwives were done to eliminate the "granny" midwives and introduce a model of care that lacked any practices considered superstitious or otherwise unsafe. The state as policy maker promoted a dual system of care with the training of African American lay midwives. The persistence of lay midwifery in South Carolina contributed to a system of separate care one for African American women and another for white women.

Midwives in order to practice had to be sanctioned by the state Public Health Department. All midwives had to attend training programs and become certified to practice. Completion of training at the Midwifery Institute were indicators of meeting the requirement to become a midwife. The public health organization of the state could use

midwifery-training programs to aid in promoting safe and hygienic care to pregnant women, and inform the community that only certain women were capable of becoming midwives.

Uniqueness of Lay Midwifery

The social and cultural fabric of the rural South Carolina viewed midwifery as a natural part of the environment. Midwives had been delivering women in the community for quite some time and the tradition continued. The continued presence of the midwife in the community enhanced the relationship between the midwife and her client. The local midwife was a health care provider and a neighbor. The community recognized the importance of the midwife and depended on her for care at delivery and after childbirth. Many of the midwives developed a relationship with families in which the midwife chosen to deliver a woman would not change for subsequent pregnancies. The midwife as a nurturer and a companion at the time of delivery continued for years as a tradition in African American communities.

Charlotte Borst in an analysis of middle class white women and midwifery care noted that the shift in childbirth attendants was an example of the relationship of gender, class and culture.[1] Another reason for the shift from home births to hospital deliveries was the belief of women that hospital deliveries were safer.[2] Middle class white women began going to hospitals for deliveries in the early 1900s because of fear of pain, the conveniences offered at hospitals and the fear of maternal or infant complications associated with childbirth.[3]

The decisions of middle class women beginning in the 1920s to seek hospital deliveries rather than home deliveries did not occur in similar fashion in the African

American community. African American midwives provided care because there were few other options left in the segregated south. The politics of racism, poverty, segregated facilities and lack of access to hospitals contributed to the need for midwifery care in the rural South. In addition the voices of African American women as a group to effect change were limited.

African American female reformers sought to bring about changes in all aspects of African American life. Reformers such as Mary Church Terrell, Mary McLeod Bethune, and African American clubwomen sought to bring about changes that would uplift the race.[4] African American female reformers sought causes that would benefit African American health in general and increase access to health care for all African Americans. However, these reformers did not advocate for midwives in regards to arguing for the continuance of midwifery or push for increased education and advancement of midwives.

African American midwives practicing in the rural south were confronted with a variety of realities. African American midwives were at the bottom tier of the public health structure and were viewed as ancillary and expendable. Midwives were poor women providing care for poor, rural women. The midwives and their clients were not part of any organized coalition to advocate their cause.

Empowerment for Lay Midwives

Boards of Health in the South, while intending to regulate midwifery care, also provided a mechanism for midwives to exercise power and decision-making, advance their economic position, promote healthy delivery services and increase their status in their community. The impetus of the State Board of Health for the education and training

of African American lay midwives was not intended to create advancement for African American women as health care providers. Nonetheless, benefits did accrue to midwives such as job opportunities and a chance to improve their economic status. The opportunity to obtain training presented an occupational opportunity other than farming or domestic work. African Americans had limited opportunities to pursue education of any type in the South, and the opportunity for a woman to attend a school was an exception rather than the rule.

Empowerment for the women in this study provided a framework for decision-making and care giving. Written accounts of lay midwifery care do not discuss or analyze how practicing lay midwives were empowered through care giving and interactions with the public health care system. During the time when the midwives in this study practiced, the concept of empowerment had not gained popularity. However understanding this concept as the enhancement of an individual's ability to assert control over many influences in their lives makes it possible to discuss empowerment as an outcome of this study.

Empowerment emerged during the 1960s from the philosophy of Brazilian educator Paulo Friere.[5] Friere referred to the liberation of an oppressed people, which reverses the dehumanization and objectification of the oppressed people through development of their own critical consciousness.[6]

Empowerment cannot be defined in a singular way because it takes on a purpose according to the people involved. Empowerment is rooted in the social action ideology and can be viewed as a process or an outcome.[7] The process is the mechanism by which people can gain mastery over their own lives.[8] Processes of empowering include the

manner in which persons create or are given opportunities to control their own destiny and influence the decisions that affect their lives.[9] Zimmerman describes the process as a series of experiences in which individuals learn to seek a closer correspondence between their goals and a sense of how to achieve them.[10]

Through midwifery, women could become wage earners at a time when limited employment was available for African American women. For the women in this study the initial steps toward goal achievement was attending a midwifery-training program. In order to attain the goal of being admitted to a training program, prospective applicants had to obtain a recommendation from the local midwife and county health officer. Although empowerment involves an individual demand, it is sustained by the effects of collaborative actions. Collaborative actions for the women in this study required combined efforts of the midwife applicant, elder midwife, and county health officer. The effort of the elder community midwife to observe women interested in becoming a midwife sustained the prospective midwifes request to be considered for entry into a training program.

Once accepted into the program mastery of the lessons taught at the Institute was required. At Midwifery Institutes, public health nurses taught lessons about pregnancy, delivery and newborn care to the midwives. After completing the training programs midwives in this study describe their feelings of being able to provide care to women, which is an indication of being empowered. One of the midwives in describing her ability to learn what was taught said: "I studied my lessons real hard, I went and learned the lessons". [11]

The midwives in this study while conforming to state requirements, also heeded the advice of the elder community midwife in some areas. For practices not taught at the Institute such as delivering breech babies, the elder midwife took it upon herself to be sure a midwife knew how to deliver breech babies. By obtaining the training, they knew how to mange safe care and intervene when a doctor was not available.

Midwives, when necessary, did initiate and perform emergency actions at some births that saved lives. The ability to provide immediate intervention when complications such as breech deliveries or seizures presented is an exemplar of the ability to act quickly. The midwife, while considering options for an emergency case had to determine whether it was feasible to try to locate a doctor. It is possible that while not frightened at the prospect of delivering women with complications, midwives felt there was no other alternative. As one of the midwives in this study said in describing a woman who had a seizure at the time of delivery: "We wasn't suppose to be delivering women with seizures, but what can you do?"[12]

Empowerment of midwives in the study also made it possible for them to influence others in the community. Midwives in this study adhered to Board of Health regulations that pregnant women had to be screened by a physician before engaging a midwife for care. Important actions by empowered midwives caused many pregnant women to obtain prenatal screening by a physician. Encouraging pregnant women to seek prenatal care aided in identifying high-risk pregnancies and contributed to the safety of pregnant women. Empowerment for these women provided a framework for decision-making in matters such as when to seek assistance from a physician and which patients they could accept for care. Midwives were not forced to accept pregnant women for

deliveries. The midwife, while adhering to state rules, had the power to decline assistance or care giving to women who did not meet the criteria for being delivered by a midwife.

Spiritual Guidance

Spiritual guidance is reflected in each of the interviews as the women recount how they depended on God to help them in difficult deliveries and when they were having problems, including those of a personal nature. The midwives did not acknowledge a spiritual or divine calling to become midwives. Granny midwives that were predecessors to trained midwives in general acknowledged a calling to become a midwife.[13] [14] The former midwives acknowledged the influence of religion in their care giving experiences and in their training. The women were able, by their accounts, to deliver babies without adverse effects to the women whom they cared for in part due to faith in God and due to the training received.

Intuitive Abilities

In the interviews, it was noted, that at the time of a delivery, patience seemed to be foremost in assisting them along with scientific knowledge about birth. This combination of nature and science embodies much of how these women provided care. Being able to take charge of cases based on their knowledge and their intuitive ability is to be appreciated. When the women talk about knowing when to have the woman lie down in bed and get ready for the baby to come, there was no internal exam to provide them with information regarding the status of cervical dilatation.

However, the intuitive ability, sometimes referred to as "mother wit" in other accounts about granny midwives, was apparently in action and operating to assist these women. As one of the women in the study said:

> they taught us a lot at the school, but there was somethin in me that just told me when the time was near for a woman to birth a baby.[15]

Nature and science provided these women, who possessed little formal education, with the requisite ability and skills to deliver more than 1,000 babies.

Institutional Relationships

The system of midwifery provided numerous occasions for interaction with public health nurses who also influenced the midwives care. Through this interaction, transference of knowledge and attitudes occurred in both directions.

An account in a public health journal reflecting on what the nurse learns from the midwife provides additional insight. Laura Blackburn, the Midwife Supervisor in South Carolina for more than 20 years, noted that in addition to the midwife being taught by the nurse, the midwife also taught the nurse.

> I have learned," said another nurse, "that those qualities of the spirit which the midwife possesses give the patient security and confidence. The midwife's patient had been in labor all night and all day and the midwife had been with her all of this time. The nurse was called and she in turn called the doctor. After examining the patient, he told the midwife and the nurse to go home and get some rest as the baby would not be born until the 'rising of the sun.' There was only the patient's mother to be left with her. The nurse left. The doctor left. The patient and her mother began to cry. Although the midwife was very tired, she decided to stay with the patient. Due to a fibroid tumor, the baby was born dead two hours after the doctor left. No one can estimate how much it meant to the patient and her mother to have the midwife standing by and helping to comfort them in such a trying experience. It meant more than soap and water, more than techniques, more that arrangement of the table and bed.[16]

While public health nurses provided the necessary educational training for lay midwives, there were lessons that the nurses could learn from the midwives. The nurse who

maintained objectivity could learn from the midwife qualities important in care giving. The nurse could learn about the importance of patience when caring for a client and how comforting the patient is as much a part of nursing as the task oriented measures.

Conclusion

The intent of Board of Health program initiatives were to increase the chances for a woman to have a safe delivery while minimizing and/or preventing complications of pregnancy and childbirth. The mortality rate declined, in part due to increased access to health care, for African American women. Additionally, the decrease in the mortality rate was also directly related to the actions of the midwives.

Lay midwifery persisted until the early 1970s as a way of life for African Americans in rural Georgetown County. Adherence to institutional rules by midwives increased rural women's exposure to the health care system. Lay midwifery aided the initiatives of the state by providing a measure of safety for the pregnant woman.

The Board of Health requirements provided a supervisory structure for lay midwives. Greater authority and control over the care giving became the driving force to ensure adherence to state guidelines for midwifery practice. However, the women in this study do not appear to view the rules and regulations for midwifery practice in South Carolina as inhibiting their care giving.

Lay midwives were not considered as power wielders or having any position on the hierarchical rung existing in the health care system. However, their care contributed to the health status of pregnant women whom they cared for while their interactions with the physicians and nurses provided a basis for communication about the status of clients and the opportunity to share their concerns about cases. Overall, the women in this study,

who worked at the lowest strata within the health care workforce, became important contributors to improved health outcomes for a population of rural women.

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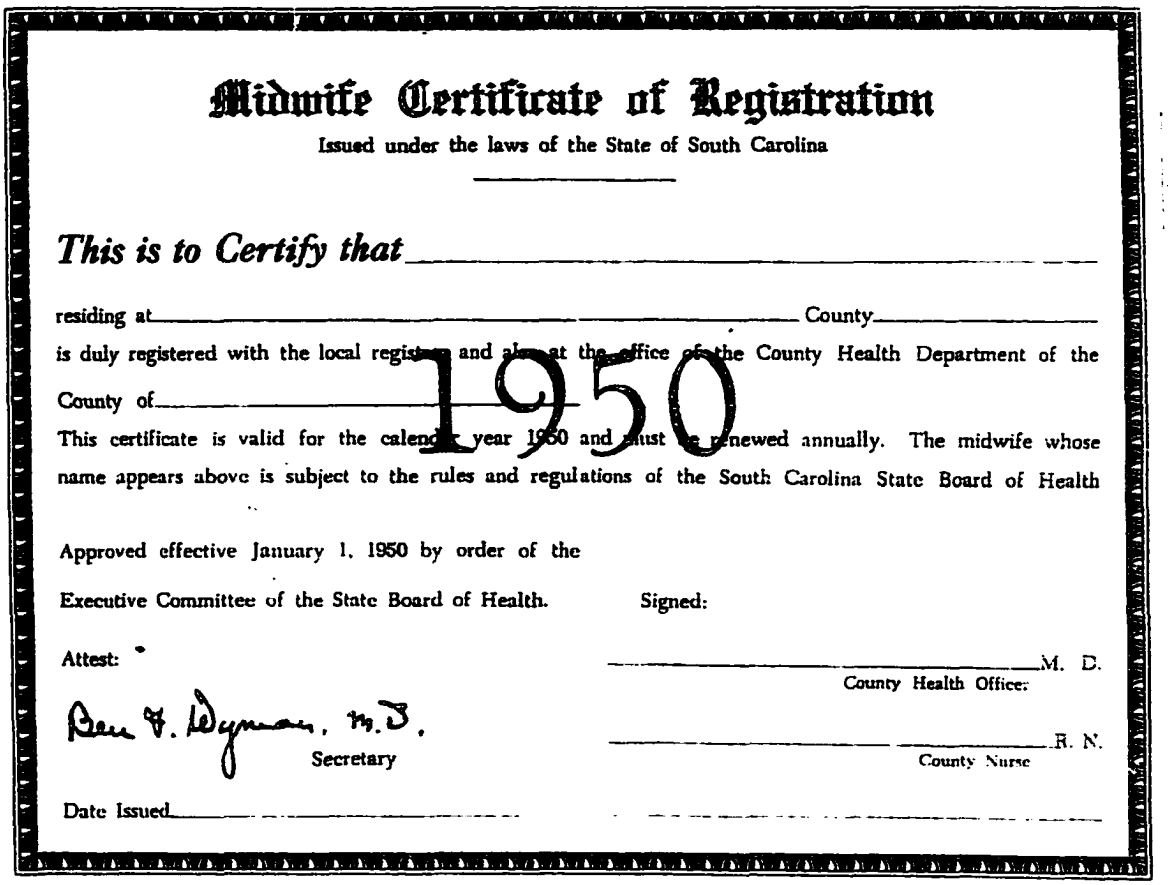
APPENDIX 1



Midwife Certificate of Registration

Issued under the laws of the State of South Carolina

This is to Certify that _____

residing at _____ County _____

is duly registered with the local registrar and also at the office of the County Health Department of the County of _____ 1950

This certificate is valid for the calendar year 1950 and must be renewed annually. The midwife whose name appears above is subject to the rules and regulations of the South Carolina State Board of Health

Approved effective January 1, 1950 by order of the Executive Committee of the State Board of Health.

Signed:

Attest: Ben F. Wyman, M.D.
Secretary

_____ M. D.
County Health Officer

_____ R. N.
County Nurse

Date Issued _____

APPENDIX 2

RULES AND REGULATIONS GOVERNING MIDWIVES IN THE STATE OF SOUTH CAROLINA

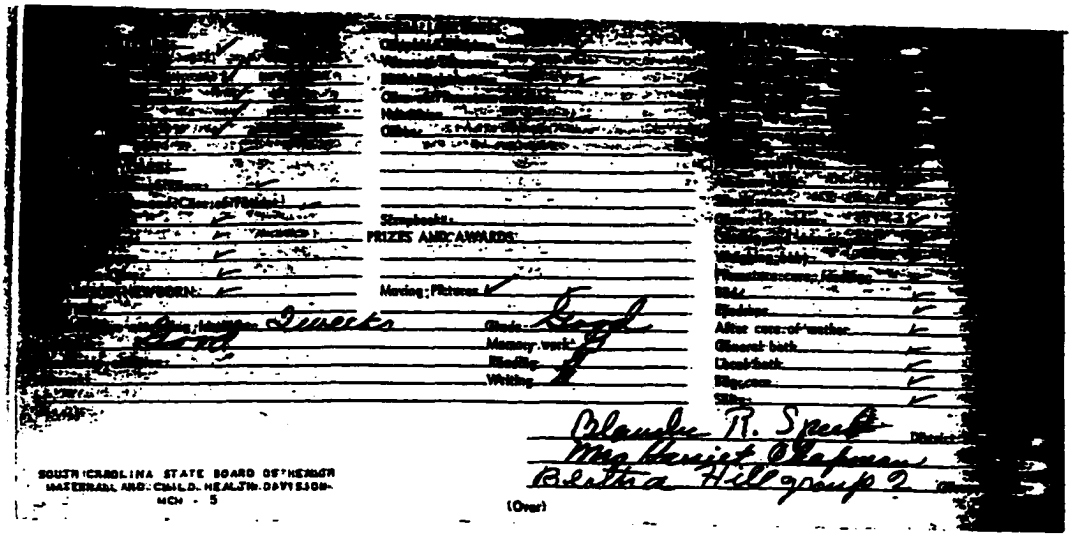
I. (1) All midwives shall register with the local registrar and also at the County Health Department.
(2) In each county midwives shall be subject to the supervision and control of the county health officer.
(3) Midwives shall report to the public health nurse (s) of their county, or to the county health officer whenever requested to do so.

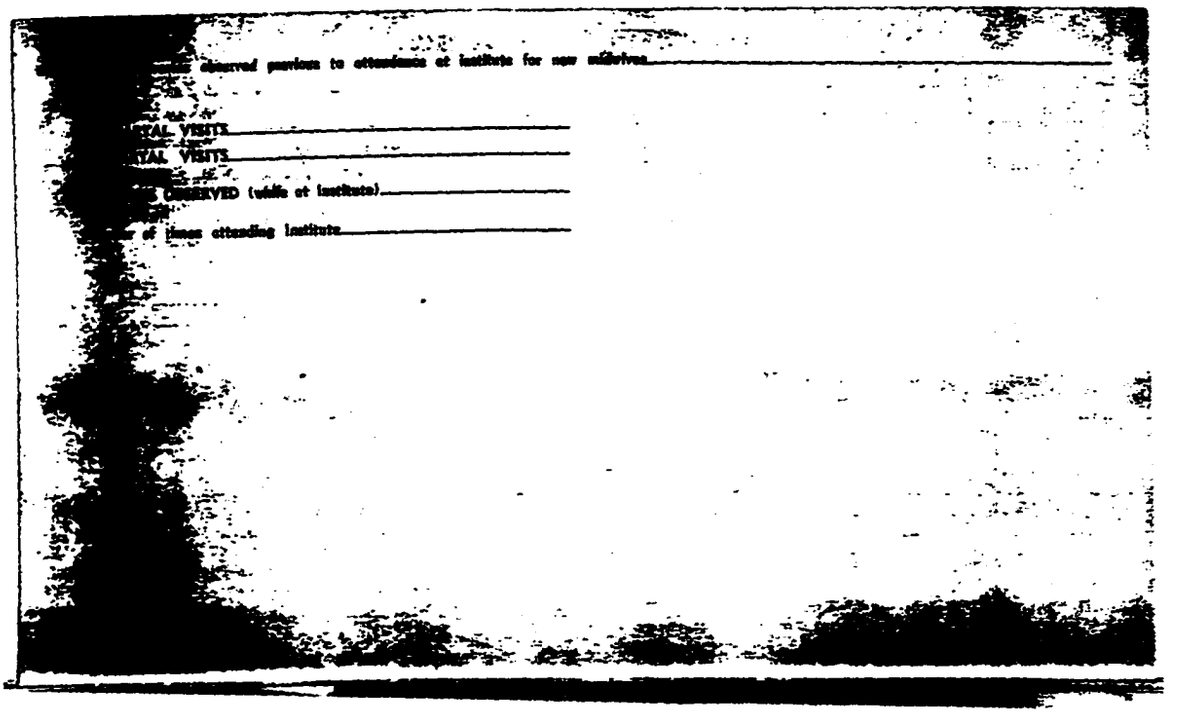
II. REQUIREMENTS FOR REGISTRATION.
(1) In order to secure a Certificate of Registration a midwife shall be able to read and write. She shall be able to see well, have average intelligence and be in good general health. She shall have an annual physical examination by a physician. She must be free from communicable diseases.
(2) Every midwife shall have a negative test for syphilis or shall be non-infectious.
(3) Before becoming eligible to register, all new midwives are required to attend a prescribed course of instructions of two weeks at an annual State or district midwife institute. Upon completion of this course, the certificate to practice is granted at the discretion of the health officer and may be withdrawn at his discretion.
(4) It is required that a midwife attend a two weeks institute every four years.
(5) An issuance fee and an annual renewal fee shall be charged for each certificate.

III. REGULATIONS.
(1) A midwife shall notify the County Health Department when she accepts a case for delivery. She shall also notify the county health department within twenty-four hours after delivery of a case.
(2) A midwife shall accept only patients who engage her before or during the fourth month of pregnancy and see that they have prenatal care approved by Health Director, this care to be given by a licensed medical doctor or at a clinic conducted by a licensed medical doctor.
(3) A midwife shall not deliver a dwarf or crippled person without written permission from a licensed physician.
(4) A midwife shall go on a case completely equipped with all necessary supplies.
(5) Before attending a woman in confinement a midwife shall wash her hands with warm water and soap.
(6) She shall keep herself, her patient, bed, clothing and all that comes in contact with the patient clean
(7) She shall not pass her fingers or any instruments into the birth canal of the woman for the purpose of examination or for any other purpose.
(8) She shall not give an injection of any kind into the birth canal without orders from the physician.
(9) A midwife shall not give drugs of any kind except under the direction of a physician or the county health officer.
(10) A midwife shall endeavor to secure the assistance of a physician if the child is not born after eighteen hours of labor or if anything goes wrong.
(11) As soon as the cord is cut, it shall be dressed with a sterile dry dressing.
(12) Within an hour after the child is born, two drops of 1 per cent solution of nitrate of silver shall be dropped into each eye.
(13) Every case of "baby's sore eyes" or reddening of the eyelids shall be reported at once to a physician and to the county health department.
(14) A midwife shall not leave one case to go on another or attempt to handle two or more deliveries at the same time.
(15) The midwife shall remain with her patient for a period of not less than two hours following delivery.
(16) Every midwife shall report all births she attends within ten days to the local Registrar.
(17) If a baby is born too soon, or weighs less than 5½ pounds, the midwife shall report it to the County Health Department as soon as the baby is born.
(18) No person who has failed to obtain and hold a certificate as set forth above shall practice midwifery in this State.

IV. PENALTY.
Any person violating any of the above rules or regulations shall, upon conviction, be punished as provided in Section 2314, Vol. III, Code of Laws of South Carolina, 1922. (This section provides that any one failing to comply with any of the rules or regulations of the Executive Committee of the State Board of Health shall, upon conviction, be fined not to exceed $100.00 or imprisoned not to exceed thirty days.)

APPENDIX 3





observed previous to attendance at institute for new mothers

VISITS

VISITS

OBSERVED (visits at institute)

of times attending institute

APPENDIX 4

CONSENT FORM

The purpose of this study is to learn about your experiences of providing care to women during childbirth. I will also ask you to tell me about your training and discuss your feelings about why you chose to become a midwife. You can take as much time as you like to tell me your story. It is hoped that information obtained from this study will provide an understanding of what it was like for you as a midwife. Your participation in this study is voluntary. You can withdraw from this study at any time. No adverse consequences will result from you either participating or declining to participate in this study. The conversation will be tape-recorded and you may, at any time, ask me to turn off the tape recorder. You can refuse to answer any question at any time and you can decline participation at any time. The tape recording of the interview will be typed, and names or identifying information will be removed from the typed copy of the taped interview. Your confidentiality is provided to the extent provided by law. Authorized university employees or other agents may also review your tape recordings for audit purposes. I also request permission to contact you again if I need clarification about something you have told me. If you have any further questions you can contact Dr. Nancy Hogan, 305-284-3666. If you have any questions about your rights as a research subject you may contact Maria Arnold, Institutional Review Board Director, at the University of Miami 305-243-3327.

Name: Date:

APPENDIX 5

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

MEMORANDUM

TO: Nancy Hogan, Ph.D.

FROM: Rachel Lyn Sachs, M.Ed.
IRB Administrator
Human Subjects Office

DATE: October 18, 2000

SUBJECT: Exempt

TITLE: "The Experiences of African-American Midwives in Rural South Carolina from 1950-1970"

The Institutional Review Board (IRB) has found this protocol to be exempt from the 45 CFR 46 Protection of Human Subjects Policy. This exemption is in accordance with CFR 46.101(b)(2). *"Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedure or observation of public behaviors, **unless**: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers liked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonable place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability or reputation."*

If you have any questions, please contact me at (305) 243-2079.

Human Subjects Office (M-809)
PO Box 016960 Tel: 305-243-3327
Miami, Florida 33101
Fax: 305-243-3328

APPENDIX 6

THE MIDWIVES PRAYER

Almighty God, our heavenly Father, the Author and Finisher of our lives, we give Thee our thanks for health and strength and all the joys of life.

We pray that Thou wouldst bless the mothers and fathers everywhere, make them more loving in their hearts, and more Christ-like in the things they say and do.

Guide us in this meeting, and may it be the means of preparing midwives to render service more pleasing to Thee, and more acceptable to our fellow man.

May Thy will be done and Thy kingdom come everywhere and when our work on earth is done grant that we may enter the building of God, the house not made with hands, eternal in the heavens. In Jesus' name – Amen.